

CERTIFICATE OF DEATH

Reg. Dist. No.

02297

2316

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 19 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First David Middle Geddas Last Anderson			4. DATE OF DEATH Month Feb Day 28 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Jan 1899		9. AGE (In years lost birthday) yrs. 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Jeweler	11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME George M Anderson			14. MOTHER'S MAIDEN NAME Amanda Coleman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		INFORMANT Address Anna E Anderson Cottage City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 411X DUE TO Pul. Cong. & edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO Rheumatoid Arthritis (c) Rheumatoid Arthritis					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hyattsville	(County) Prince Georges	(State) Md.
21. I certify that I attended the deceased from Feb 9th , 19 60 , to Feb 28th , 19 60 , that I last saw the deceased alive on Feb 28th , 19 60 , and that death occurred at 7:25 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyattsville, Md. DATE SIGNED Feb 28th 1960					
ACTUAL SIGNATURE Dr. Teil Bergmann		M.D. 4314 Calver St.			
PHYSICIAN'S NAME (Type) Dr. Teil Bergmann, M.D.		Hyattsville., Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/2/60	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR FEB 29 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Adams

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2391

CERTIFICATE OF DEATH

Reg. Dist. No.

02298

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Maryland		c. LENGTH OF STAY IN 1b 21- Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) 4723- Brookfield Drive S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RICHARD First HUDSON Middle BANNON Last		4. DATE OF DEATH Feb. 20th. Month 19 60 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17th. 1895
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Naval Weapons Plant	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jermiah Bannon		14. MOTHER'S MAIDEN NAME Grace A. Laird	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Mrs. Anna W. Bannon Address Same As # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Infarction Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Coronary Atherosclerosis (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs. 3 mos
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-29 , 19 56 , to 2-20 , 19 60 , that I last saw the deceased alive on 2-15 , 19 60 , and that death occurred at 4:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3409--Alabama Ave., SE Wash DC DATE SIGNED 2-20-60 ACTUAL SIGNATURE Frank S. Pellegrini M.D. 3409--Alabama Ave S.E. Wash. DC PHYSICIAN'S NAME (Type) Frank S. Pellegrini			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 23-60	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. ADDRESS 1661- Good Hope Rd. S.E. Washington, DC.		24a. REC'D BY REGISTRAR FLS 23 60 DATE	24b. REGISTRAR'S SIGNATURE Charles S. Kraus

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)
15M 9/58

100-2

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

In the Matter of the Estate of JAMES H. HARRIS, Deceased.
The People of the State of New York, by the Attorney General, vs.

James H. Harris, Plaintiff,
vs.

James H. Harris, Defendant.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2302 CERTIFICATE OF DEATH

02299

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland		c. LENGTH OF STAY IN 1b Admitted 5/9/1956	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home		d. STREET ADDRESS 2126 N Street, N.W.	
3. NAME OF DECEASED (Type or print) First MARGARET Middle BARBER Last		4. DATE OF DEATH Month FEBRUARY Day 5 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1870
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 8 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cork County, Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Pigott		14. MOTHER'S MAIDEN NAME Ellen Barry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT (Nephew) Mr. Sidney Cousins, Jr.		Address 8814 Ridge Road, Bethesda, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 month 8 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/22/1956 to 2/5/1960 , that I last saw the deceased alive on 2/4/1960 , and that death occurred at 2:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 322- H. Street, N.E. 2-5-1960			
ACTUAL SIGNATURE Thomas F. Collins		M.D. 322- H. Street, N.E. 2-5-1960	
PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.		Washington 2, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF February 9, 1960	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Thompson		ADDRESS 1300 N St. N.W. Wash. D.C.	
24a. REC'D BY REGISTRAR FEB 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. *Journal of Management Studies*, 1991, 28, 1.

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
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Page 4

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2317

CERTIFICATE OF DEATH

Reg. Dist. No.

02300

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 60 Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last L I Z Z I C Bassham		4. DATE OF DEATH Month Day Year February 26, 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March --1893
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tenn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Simon P. Robertson	
14. MOTHER'S MAIDEN NAME Annie Phillips		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO NONE	
16. SOCIAL SECURITY NO. 421-32-936		17. INFORMANT Bessie Bassham 5619 31st Ave., Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO (b) Cordia Vascular Renal Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Doctor		INTERVAL BETWEEN ONSET AND DEATH 1 Hr 5 Yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 55, 19, to Feb 26, 19 60, that I last saw the deceased alive on Feb 25, 19 60, and that death occurred at 9 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Harold Heiges		ADDRESS (Street, city or town, state) 1835 Eye St NW DC 20006	
DATE SIGNED FEB 29 1960		22. LOCATION (City, town, or county) (State) Barton Ala.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2/27/60	
22c. NAME OF CEMETERY OR CREMATORY New Barton Cem.		22d. LOCATION (City, town, or county) (State) Barton Ala.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. 2901-14th St. N.W. Wash. D.C.		24a. REC'D BY REGISTRAR FEB 29 1960	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

CENTRAL OF DEATH

1917

Residence in

2010 1st Ave.

Wm. J. ...

March 1917

Acute ...

Simon T. Robertson

Carney Thompson
Carmichael, Paul ...

October

New Boston ...

Removal ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2374

CERTIFICATE OF DEATH

Reg. Dist. No.

02301

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				d. STREET ADDRESS 421 Prince George Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William Middle Ellsworth Last Beall				4. DATE OF DEATH Month February Day 12 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 19, 1875	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min. 84		IF UNDER 24 HRS. Months 84 Days 84 Hours 84 Min. 84			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper				10b. KIND OF BUSINESS OR INDUSTRY Retail store			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James Henning Beall				14. MOTHER'S MAIDEN NAME Elizabeth Burdette			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 217-32-1832			
17. INFORMANT Miss Leone Barrett, Laurel, Md				Address Laurel, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DISEASE DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE DIARRHEA, CAUSE UNDETERMINED				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 25 DEC , 19 59 , to 12 FEB , 19 60 , that I last saw the deceased alive on 12 FEB , 19 60 , and that death occurred at 3 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard Compton, M.D.				ADDRESS (Street, city or town, state) 612 MAIN STREET			
DATE SIGNED J. Richard Compton, M.D.				LAUREL, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/15/60			
22c. NAME OF CEMETERY OR CREMATORY Hushup Family Cem.				22d. LOCATION (City, town, or county) (State) Laurel, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Sanderson, Laurel, Md				24a. REC'D BY REGISTRAR DATE FEB 16 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Hines							

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES HENRY		JAN 10 1900	
AGE		SEX	
35		M	
PLACE OF BIRTH		DATE OF BIRTH	
BALTIMORE, MD		JAN 10 1865	
OCCUPATION		CAUSE OF DEATH	
Carpenter		Heart Disease	
MANNER OF DEATH		PLACE OF DEATH	
Natural		Home	
TIME OF DEATH		HOURS OF DEATH	
10:00 AM		10:00 AM	
DAY OF DEATH		MONTH OF DEATH	
Jan 10		Jan	
YEAR OF DEATH		CENTURY OF DEATH	
1900		19	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. Smith		J. H. Smith	
DATE OF SIGNATURE		DATE OF SIGNATURE	
Jan 10		Jan 10	

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE THAN THAT FOR WHICH IT WAS ISSUED. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE THAN THAT FOR WHICH IT WAS ISSUED.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

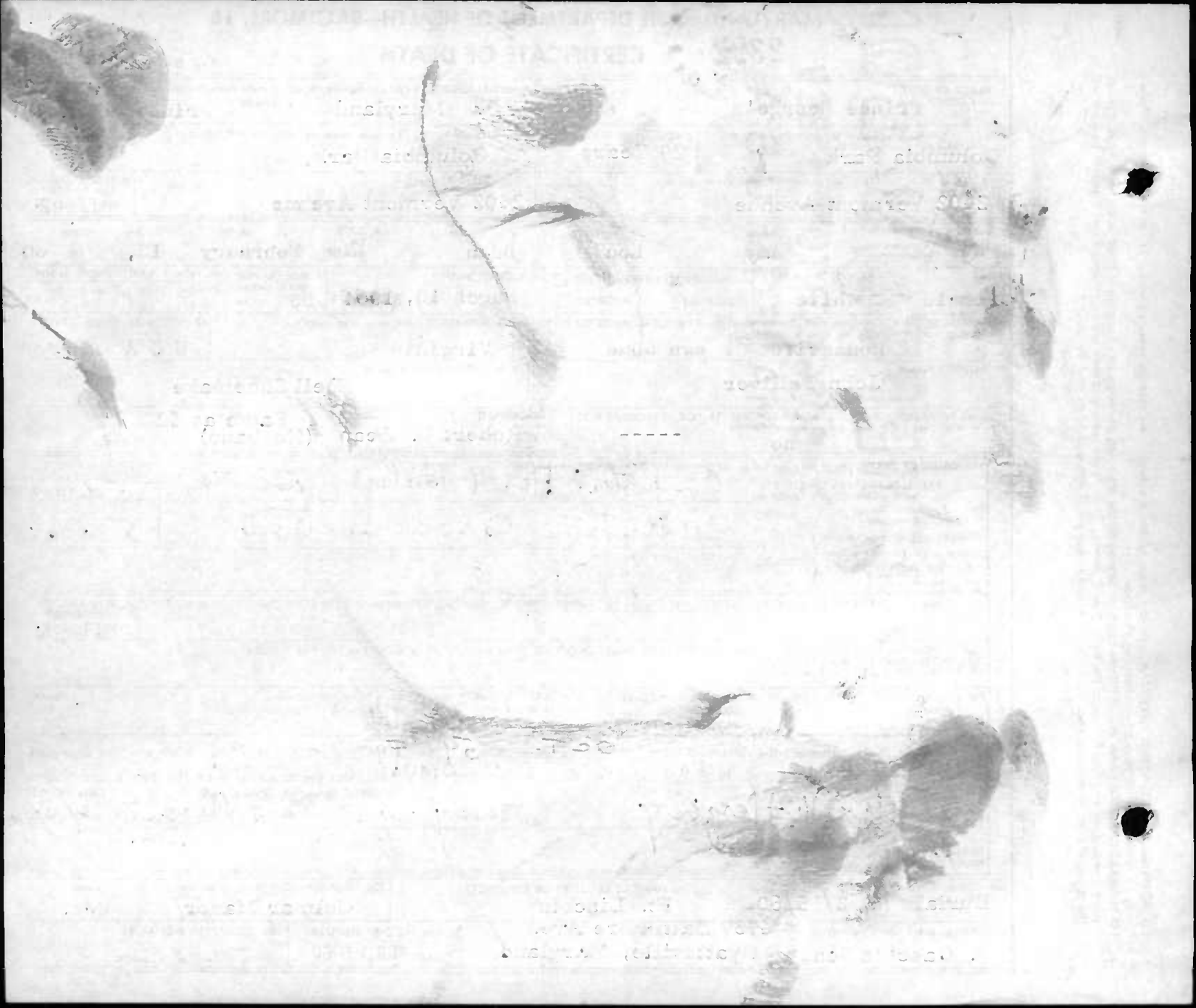
2392

CERTIFICATE OF DEATH

Reg. Dist. No.

02302

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Columbia Park		c. LENGTH OF STAY IN lb 29 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2402 Vermont Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Amy Middle Lou Last Bean		4. DATE OF DEATH Month February Day 12, Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1904
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 3 Days 5	11. IF UNDER 24 HRS. Hours 5 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Tolliver		14. MOTHER'S MAIDEN NAME Bell Shoemaker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Robert L. Bean		Address Same as #2 (Husband)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Competitive Heart Failure acute 199.2 DUE TO Metastatic Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 5 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT. 1959 to FEB. 12, 1960 , that I last saw the deceased alive on FEB. 12, 1960 , and that death occurred at 3:40 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Tulax M. Herzberg		ADDRESS (Street, city or town, state) 2016-Prep St, Seat Pleasant Md. DATE SIGNED 2/12/60	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial	22b. DATE THEREOF 2/15/60	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	22d. LOCATION (City, town, or county) (State) Colmar Manor Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE FEB 16 '60	
4739 Baltimore Ave. Hyattsville, Maryland		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	



2393

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine, Md.				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARIAN Middle E Last BEAN				4. DATE OF DEATH Month FEB Day 18 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 9, 1871	9. AGE (In years last birthday) yrs. 88	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles S. Early				14. MOTHER'S MAIDEN NAME Georgia Berry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. NONE		INFORMANT Address James A. Bean, Brandywine, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.3 153.3 DUE TO Leukemia and Anemia Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Carcinoma of Sigmoid DUE TO 1 1/2 yr (c) none							INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 9-10 , 19 54 , to 2-18 , 19 60 that I last saw the deceased alive on 2-18 , 19 60 , and that death occurred at 11:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard H. Dobson M.D.				ADDRESS (Street, city or town, state) Brandywine, Md.			
PHYSICIAN'S NAME (Type) Richard H. Dobson, M.D.				DATE SIGNED BRANDYWINE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-22-60	22c. NAME OF CEMETERY OR CREMATORY St Pauls	22d. LOCATION (City, town, or county) (State) Baden, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland			24a. REC'D BY REGISTRAR FEB 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

1933

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of birth: *Jan 1, 1888*
5. Date of death: *Dec 15, 1933*
6. Place of death: *Home*
7. Cause of death: *Heart disease*
8. Signature of physician: *J. H. Smith*
9. Signature of registrar: *W. B. Jones*
10. Signature of informant: *M. E. Doe*

2318 CERTIFICATE OF DEATH

02304

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 8 Days d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Ann Arundall c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo d. STREET ADDRESS none e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First HOWARD Middle E Last BELL			4. DATE OF DEATH Month 2 Day 23 Year 1960		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4-29-03		9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 56 Days 23 Hours 19 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		12. KIND OF BUSINESS OR INDUSTRY Clothing		13. BIRTHPLACE (State or foreign country) Washington D.C.	
14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. FATHER'S NAME Howard E. Bell		16. MOTHER'S MAIDEN NAME Cinnie Baue	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		18. SOCIAL SECURITY NO. None		19. INFORMANT Mrs. Esther Tompkins Address 2800 Cornhill Rd. Glenville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerotic Heart Disease DUE TO (c) 20 years					INTERVAL BETWEEN ONSET AND DEATH 20 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LOBAR PNEUMONIA - MULTIPLE PULMONARY EMBOLI					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Riverdale		20g. (County) Riverdale		20h. (State) Md.	
21. I certify that I attended the deceased from 2-16 , 19 60 , to 2-23 , 19 60 , that I last saw the deceased alive on 2-23 , 19 60 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE Albert Roth		M.D. Riverdale		ADDRESS (Street, city or town, state) 2/24/60	
PHYSICIAN'S NAME (Type) Dr. Albert		Roth M.D. Riverdale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-26-1960		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVE	
22d. LOCATION (City, town, or county) WASHINGTON D.C.		22e. (State) D.C.		22f. REGISTRAR'S SIGNATURE Arthur S. Kraus	
23. FUNERAL HOME'S SIGNATURE Lee Funeral Home		ADDRESS H + Mass Ave NE		24a. REC'D BY REGISTRAR DATE FEB 29 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02305

Reg. Dist. No.

2319

1. PLACE OF DEATH a. COUNTY MARYLAND Prince Georges Hospital b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chervey c. LENGTH OF STAY IN lb 65 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale d. STREET ADDRESS 5006 Tuckerman St.		
3. NAME OF DECEASED (Type or print) ROBETTA SAPPINGTON BENTON First Middle Last 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH March 1, 1910 9. AGE (In years last birthday) 49 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY West Virginia 11. BIRTHPLACE (State or foreign country) West Virginia 12. CITIZEN OF WHAT COUNTRY?			4. DATE OF DEATH Month Day Year Feb. 20th, 1960 13. FATHER'S NAME John A. Manual 14. MOTHER'S MAIDEN NAME Etta Sappington 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. NONE 17. INFORMANT William H. Benton Address Same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 816X DUE TO Coronary Thrombosis (circumflex left coronary) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Hypertensive Coronary Arteriosclerotic Heart Disease years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple fractures, contusions and lacerations secondary to automobile accident.			INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 hour 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in automobile in collision with another automobile 20c. TIME OF INJURY Month, Day, Year Hour 10:30 P.M. 1/16 1960 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 20f. (City or town) Seat Pleasant Pr. Geo. Md. (County) (State)			21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		
ACTUAL SIGNATURE John T. Maloney M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) JOHN T. MALONEY, MD. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED FEB. 21, 1960			22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2-24-60 22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery 22d. LOCATION (City, town, or county) Bladensburg, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers ADDRESS Riverdale, Md. 24a. REC'D BY REGISTRAR FEB 24 '60 24b. REGISTRAR'S SIGNATURE					

MEDICAL CERTIFICATION

077

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16

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2320

CERTIFICATE OF DEATH

02306

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 1556-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LELAND MEMORIAL HOSPITAL		d. STREET ADDRESS 112 SHAW AVENUE	
3. NAME OF DECEASED (Type or print) William M. Biddington		4. DATE OF DEATH Month February Day 1 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/29/96
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRUGGIST		10b. KIND OF BUSINESS OR INDUSTRY GRUBB PHARMACY CO.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES ROBERT BIDDINGTON		14. MOTHER'S MAIDEN NAME MARY ROBB	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 232-01-1273	
17. INFORMANT Mrs. Sadie M. Biddington, 112 Shaw Ave. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCVD DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 12 hr 2 yrs. -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 59 , to 25 Jan , 19 60 , that I last saw the deceased alive on 25 Jan , 19 60 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10511 Summit Avenue, Kensington, Maryland DATE SIGNED			
ACTUAL SIGNATURE Horace W. Bernton M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Horace W. Bernton, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/4/60	22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. FULFORD, INC.		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR Raymond A. Ziska		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradbury Heights</u>		c. LENGTH OF STAY IN 1b <u>25</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>		d. STREET ADDRESS <u>4401 S. ST. SE</u>	
3. NAME OF DECEASED (Type or print) <u>WALTER WILFRED BIRD SR</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6.28.1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEY.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BLACKSMITH</u>	
11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWIN BIRD</u>		14. MOTHER'S MAIDEN NAME <u>MARY ANN JESSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>166-10-3833</u>	
17. INFORMANT <u>WALTER W. BIRD JR.</u>		Address <u>4401 S. ST. SE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage, sub</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension, severe</u> DUE TO (c) <u>undetermined</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb-4</u> , 19 <u>60</u> , to <u>Feb-5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb-4</u> , 19 <u>60</u> , and that death occurred at <u>6:55 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest E. Cornelsen</u>		ADDRESS (Street, city or town, state) <u>4400 Bowen Rd SE</u>	
PHYSICIAN'S NAME (Type) <u>ERNEST E. CORNELSEN MD</u>		DATE SIGNED <u>2/5/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2.6.1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Smithfield Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pittsburgh. Penna</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		ADDRESS <u>300.4th st NE</u>	
24a. REC'D BY REGISTRAR <u>FEB 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1

DECEASED

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Age at Death

Sex

Color

Marital Status

Occupation

Education

Religion

Place of Birth

Date of Birth

Place of Birth

Date of Birth

Place of Birth

Date of Birth

Place of Birth

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MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

2375 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN b. 01 Laurel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Nute Blankenship				4. DATE OF DEATH Month Day Year February 11 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1871		9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Steve Blankenship				14. MOTHER'S MAIDEN NAME Anne Fraizer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension - arteriosclerosis (c) Smoking						INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/11 1960 , to 2/11 1960 , that I last saw the deceased alive on 2/11 1960 , and that death occurred at 9 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE B. P. Warren M.D.							
PHYSICIAN'S NAME (Type) B. P. Warren, M.D. 305 Prince George Street, Laurel, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		2/13/60		St. Lincoln Cemetery		Calmar, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Dr. W. H. Sanderson Laurel Md				24a. RECEIVED BY REGISTRAR DATE FEB 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

02309

2321

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PR. GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. LENGTH OF STAY IN 1b 9 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John First Brandenbougher Middle A		4. DATE OF DEATH Feb. Month 12 Day 1960 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1896
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Naval Ord. Lab. Hastings, Minn.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Peter Brandenbougher		14. MOTHER'S MAIDEN NAME Alma Barber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 4/9/18-6/16/19		16. SOCIAL SECURITY NO. 469-01-7022	
17. INFORMANT Margaret M. Brandenbougher, wife		Address above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INFARCTION DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last, (b) CEREBRAL ARTERY THROMBOSIS DUE TO 18 HRS (c) CEREBRAL ARTERIO SCLEROSIS 6 MONTHS		INTERVAL BETWEEN ONSET AND DEATH 18 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 1 , 19 59 , to FEB 12 , 19 60 , that I last saw the deceased alive on FEB 12 , 19 60 , and that death occurred at 11:35 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel J. N. Sugar M.D.		ADDRESS (Street, city or town, state) 4300 KAYWOOD DRIVE DATE SIGNED 2/12/60	
PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR		MT. RAINIER, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/16/60	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Columbia Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Valley Funeral Home ADDRESS 3300 RHODE ISLAND		24. REC'D BY REGISTRAR FEB 17 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02310

2395

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphia				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paint Branch Rest Home				d. STREET ADDRESS 311 Aspen St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle Louise Last Brickert				4. DATE OF DEATH February 19 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1862		9. AGE (In years last birthday) 97 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greenwood, Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Tresslar				14. MOTHER'S MAIDEN NAME Hannah Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Hugh R. Brickert, 311 Aspen St., N.W., D.C. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute myocardial Failure following coronary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 28, 1959, to Feb. 19, 1960, that I last saw the deceased alive on Feb. 19, 1960, and that death occurred at 9:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Oliver E. Thompson M.D. 1835 Eve St. N. W. Wash. D. C. PHYSICIAN'S NAME (Type) Oliver E. Thompson, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-22-1960		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Fredericksburg, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE Demaine Funeral Home, Alexandria, Virginia. ADDRESS				24a. REC'D BY REGISTRAR DATE FEB 23 '60		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02311

2396

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Suitland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4612--Lacy Ave., S.E.		d. STREET ADDRESS 4612--Lacy Ave., S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELZIE Middle C. Last BRIGHTWELL		4. DATE OF DEATH Month Feb. 16th Day 19th Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Sept. 1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker		10b. KIND OF BUSINESS OR INDUSTRY Lincoln Mem. Cem.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Millard G. Brightwell		14. MOTHER'S MAIDEN NAME Jane C. Pickerall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 577-34-7012	
17. INFORMANT Myrtle E. Brightwell		Address 4612--Lacy Ave Suitland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary thrombosis Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 30 minutes.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 4, 1960, to Feb. 16, 1960, that I last saw the deceased alive on Feb. 12, 1960, and that death occurred at 1:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED No. 2 Parkway Dr. Forest Hghts Maryland 2-16-60 ACTUAL SIGNATURE Dr. Etienne Szollosi M.D. PHYSICIAN'S NAME (Type) Etienne Szollosi, Dr. No. 2 Parkway Dr., Forest Hghts, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 19-60	
22c. NAME OF CEMETERY OR CREMATORY St. Barnabas Cemetery		22d. LOCATION (City, town, or county) (State) Oxon Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Sumner Bros		24a. REC'D BY REGISTRAR DATE FEB 18 '60	
ADDRESS 1661-9d Hager Rd wash DC SE		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

2322

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Jimmie R Brooks				4. DATE OF DEATH Feb 14 1960			
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1942		9. AGE (In years lost birthday) 17 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Helen Brooks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Thomas Brooks Westwood md Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 057.0 Meningococcal Meningitis DUE TO (b) Broncho pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 Feb , 19 60 , to 14 Feb , 19 60 , that I last saw the deceased alive on 14 Feb , 19 60 , and that death occurred at 7:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. B. Sasscer				ADDRESS (Street, city or town, state) Upper Marlboro, Md. DATE SIGNED 2-14-60			
PHYSICIAN'S NAME (Type) Dr. R. B. Sasscer M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		2-18-60		Church am		Aquasco md	
23. FUNERAL DIRECTOR'S SIGNATURE Geo. E. Nelson aquasco md				ADDRESS		24a. REC'D BY REGISTRAR FEB 17 '60 DATE	
						24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

3332

Given under my hand and the seal of the Registrar-General of Births, Deaths and Marriages, for the District of ...

Witness my hand and the seal of the Registrar-General of Births, Deaths and Marriages, for the District of ...

At ... this ... day of ... 19...

Signature of Registrar-General

Signature of Registrar-General

Signature of Registrar-General

Signature of Registrar-General

Signature of Registrar-General

Signature of Registrar-General

Signature of Registrar-General

Signature of Registrar-General

Signature of Registrar-General

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Signature of Registrar-General

Signature of Registrar-General

Signature of Registrar-General

Signature of Registrar-General

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02313

2397

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROONE		c. LENGTH OF STAY IN 1b 50 YRS. X CROONE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle I. Last BROOKS		4. DATE OF DEATH Month FEB. Day 9 Year 1960	
5. SEX MALE	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 31, 1894
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME LEANDER BROOKS		14. MOTHER'S MAIDEN NAME ANNIE PINKNEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT ELIZABETH O BROOKS (WIFE)		Address CROONE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 715X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) INANITION. DUE TO (c) DECUBITUS ULCERS			INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 7-10 DAYS 10-12 MOS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DISCISE HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN , 19 59 , to FEB , 19 60 , that I last saw the deceased alive on FEB. 9 , 19 60 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles W. Cadenhead		ADDRESS (Street, city or town, state) 3904 E 7 ST. - UPPON HANNING MD	
DATE SIGNED 4-60			
PHYSICIAN'S NAME (Type) Charles W. Cadenhead			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 13-60	
22c. NAME OF CEMETERY OR CREMATORY Brooks Church		22d. LOCATION (City, town, or county) (State) Nottingham P.O. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Kelson		ADDRESS agasco md	
24a. REC'D BY REGISTRAR FEB 11 '60		24b. REGISTRAR'S SIGNATURE Carlton S. Kelson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

1. NAME OF DECEASED JAMES EARL RAY	
2. DATE OF DEATH 4/4/68	
3. PLACE OF DEATH MEMPHIS, TENNESSEE	
4. CAUSE OF DEATH SHOOTING	
5. MANNER OF DEATH HOMICIDE	
6. PLACE OF BIRTH MOBILE, ALABAMA	
7. DATE OF BIRTH 1/19/28	
8. SEX MALE	
9. RACE WHITE	
10. OCCUPATION ATTORNEY	
11. MARITAL STATUS SINGLE	
12. EDUCATION HIGH SCHOOL GRADUATE	
13. RELIGION METHODIST	
14. SIGNATURE OF DECEASED (None)	
15. SIGNATURE OF WITNESS (None)	
16. SIGNATURE OF DECEASED'S NEXT OF KIN (None)	
17. SIGNATURE OF DECEASED'S ATTORNEY (None)	
18. SIGNATURE OF DECEASED'S MINISTER (None)	
19. SIGNATURE OF DECEASED'S CHURCH (None)	
20. SIGNATURE OF DECEASED'S FUNERAL HOME (None)	
21. SIGNATURE OF DECEASED'S BURIAL PLACE (None)	
22. SIGNATURE OF DECEASED'S CEMETERY (None)	
23. SIGNATURE OF DECEASED'S INTERMENT (None)	
24. SIGNATURE OF DECEASED'S CREMATION (None)	
25. SIGNATURE OF DECEASED'S OTHER (None)	

MEMPHIS
JAMES EARL RAY

ADDITIONAL INFORMATION
FBI MEMPHIS
APR 4 1968
JAMES EARL RAY
MEMPHIS, TENNESSEE
SHOOTING
HOMICIDE
MOBILE, ALABAMA
1/19/28
MALE
WHITE
ATTORNEY
SINGLE
HIGH SCHOOL GRADUATE
METHODIST
(None)
(None)
(None)
(None)
(None)
(None)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02314

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 Mt. Rainier			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4016 29th Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Charles Kirk Brown (Alias Nea Collier Hall)							
4. DATE OF DEATH Month February Day 8 Year 19 60							
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 5-11-94			
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Kirk Hall			14. MOTHER'S MAIDEN NAME Mary E. Saunders				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 108-05-4483		17. INFORMANT Address Helen Long; 4322 Livingston Rd., S.E., Wash.DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: 434.2 IMMEDIATE CAUSE (a) Acute congestive heart failure							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Cardiac asthma							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Feb. 9, 1960		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery			
22d. LOCATION (City, town, or county) Fredericksburg - Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons Hyattsville, Md.			24a. REC'D BY REGISTRAR DATE FEB 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kiana		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02315

2324

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Bladensburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1 4109 53rd Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Chauncy Middle Howard Last Brown				4. DATE OF DEATH Month February Day 14 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-17-01		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmaster		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hyman Brown				14. MOTHER'S MAIDEN NAME Bertha Rome			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 218-07-5452		17. INFORMANT Josef Brown; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED February 14, 1960			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 17, 1960		22c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GARDEN		22d. LOCATION (City, town, or county) (State) FALLS CHURCH VA.	
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY + SONS - 3501-14th St. N.W.				24a. REC'D BY REGISTRAR FEB 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

2

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____		DATE OF DEATH _____	
PLACE OF DEATH _____		STREET _____		CITY _____		STATE _____	
OCCUPATION _____		CAUSE OF DEATH _____		MANNER OF DEATH _____		SIGNATURE OF EXAMINER _____	
TIME OF DEATH _____		PLACE OF BURIAL _____		GRAVE _____		SIGNATURE OF FUNERAL HOME _____	
SIGNATURE OF NEXT OF KIN _____		SIGNATURE OF WITNESS _____		SIGNATURE OF JURY _____		SIGNATURE OF CLERK _____	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>				c. LENGTH OF STAY IN 1b <u>adm. 2-1-60</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL SANITARIUM</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANKS KIRBY MEADE BUTLER</u>				4. DATE OF DEATH Month Day Year <u>Feb. 10 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept-29-1876</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William CAMP BUTLER</u>				14. MOTHER'S MAIDEN NAME <u>? Woods</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>Hosp. Records LAUREL SANITARIUM</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial degeneration</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>with arteriosclerosis (422.1)</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>senile dementia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>many yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-1-</u> 19 <u>60</u> to <u>2-10-</u> 19 <u>60</u> that I last saw the deceased alive on <u>2-10-</u> 19 <u>60</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edith P. Kraemer</u> M.D.				ADDRESS (Street, city or town, state) <u>LAUREL SANITARIUM</u> DATE SIGNED <u>2-10-60</u>			
PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER</u>				<u>LAUREL MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Bradley</u> ADDRESS <u>221 Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM STEVENSON

1871

1871

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Pr. Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheltenham Md</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tippett Road Cheltenham Md</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Tippett Road Cheltenham Md</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mary Emily</i> First Middle Last				4. DATE OF DEATH <i>Feb. 19</i> Month Day Year			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 16 1878</i>	
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>domestic helper</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>unknown</i>				14. MOTHER'S MAIDEN NAME <i>unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Daughter</i> Address <i>Caroline Butler Cheltenham Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia acute</i> 480X DUE TO (b) <i>Probable "flu" or virus infection</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Senile general arteriosclerosis</i> -DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i> <i>unknown</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none of note</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>natural causes</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Feb 13</i> , 19 <i>60</i> , to <i>Feb 19</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Feb 18</i> , 19 <i>60</i> , and that death occurred at <i>3:15 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Paul C. VanNatta</i> M.D. <i>5440 Silver Hill Rd Sc DC</i> PHYSICIAN'S NAME (Type) <i>PAUL C. VANNATTA</i> <i>Suitland Md</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-23-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Brook Church</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges Co. Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George H. Nelson</i> ADDRESS <i>Aguasco Md</i>				24a. REC'D BY REGISTRAR <i>FEB 24 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2325

CERTIFICATE OF DEATH

Reg. Dist. No.

02318

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle E Last Cabel		4. DATE OF DEATH Month Feb Day 8 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Oct. 1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookbinder		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Mead		14. MOTHER'S MAIDEN NAME Millison Perkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579-01-1369	
17. INFORMANT Bessie Clements-Daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 25 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lymphadenitis, Left Neck		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-29 , 19 60 , to 2-8 , 19 60 , that I lost saw the deceased alive on 2-8 , 19 60 , and that death occurred 6,30A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm J. Holbrook M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. Wm Holbrook			
22a. BURIAL, CREMATION, REMOVAL (Specify) 2/11/60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Switzland - Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm Lee's Sons Co		ADDRESS 300 - 4th St N.E.	
24a. REC'D BY REGISTRAR FEB 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9110

7-11-1941



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Handwritten notes and stamps, including a large circular stamp in the center. The text is mostly illegible due to fading and bleed-through.

Handwritten notes and stamps, including a large circular stamp in the center. The text is mostly illegible due to fading and bleed-through.

2325

CERTIFICATE OF DEATH

Reg. Dist. No.

02319

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 8 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 2840 Bladensburg Road N.E.	
3. NAME OF DECEASED (Type or print) First James Middle C Last Carroll		4. DATE OF DEATH Month Feb. Day 5 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1877
9. AGE (In years last birthday) yrs. 82		10. IF UNDER 1 YEAR Months 12 Days 2 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		12. KIND OF BUSINESS OR INDUSTRY Dry Cleaning	
13. BIRTHPLACE (State or foreign country) Washington D.C.		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME William J Carroll		16. MOTHER'S MAIDEN NAME Mary A. Desmond	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. INFORMANT Mary A. Schrider Address 432 Ethan Allen Ave. Takoma Park Md.	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 days 5 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec , 19 59 , to Feb. 5 , 19 60 , that I last saw the deceased alive on Feb. 4 , 19 60 , and that death occurred at 12:25 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Dine Comeau		ADDRESS (Street, city or town, state) 3503 Perry St Mt. Rainier, Md.	
PHYSICIAN'S NAME (Type) Dr. Norman Comeau, M.D.		DATE SIGNED 2/5/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/8/60	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Frank Seiers Sons Co		24a. RECEIVED BY REGISTRAR 3605-14 St. N.W. Wash. D.C.	
24b. REGISTRAR'S SIGNATURE 2/5/60		24c. DATE	

1

1

STATEMENT OF DEATH

Decedent's Name: [Illegible]
Date of Death: [Illegible]
Place of Death: [Illegible]
Cause of Death: [Illegible]
Medical History: [Illegible]
Social History: [Illegible]
Family History: [Illegible]
Signature of Physician: [Illegible]
Signature of Informant: [Illegible]
Date: [Illegible]
Place: [Illegible]

2327

CERTIFICATE OF DEATH

Reg. Dist. No.

02320

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 4013 38 th.St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Cauley				4. DATE OF DEATH Month Feb. Day 3 Year 1960			
5. SEX M		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-1-60	
9. AGE (In years lost birthday) yrs. 2		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Roy Kenneth Cauley				14. MOTHER'S MAIDEN NAME Wanda Jacqueline Pullin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. —		INFORMANT Mother Address Ap # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Prematurity DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from Feb. 1, 1960 , to Feb. 3, 1960 , that I last saw the deceased alive on Feb. 3, 1960 , and that death occurred at 11:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John Perkins				DATE SIGNED 2/3/60			
PHYSICIAN'S NAME (Type) Dr. John Perkins, M.D.				ADDRESS (Street, city or town, state) Hyattsville Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 2-4-60		22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cme.		22d. LOCATION (City, town, or county) (State) Calver Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. David's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE FEB 8 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077211XUO

ORIGINALS

1937

CERTIFICATE OF DEATH

1937

Blank certificate form with horizontal lines for text entry.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02321

2303

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 14 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 49 Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5425 19th Avenue				d. STREET ADDRESS 5425 19th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle Albert Last Cheaney				4. DATE OF DEATH Month February Day 28 , Year 19 60			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-16-1883		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Policeman		10b. KIND OF BUSINESS OR INDUSTRY Met. Police Dept.		11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willis Cheaney				14. MOTHER'S MAIDEN NAME Elizabeth Martin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-36-6620		17. INFORMANT Frances Cheaney; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease. (c) Cardiovascular renal disease. DUE TO (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchiectasis, bronchial asthma.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED February 28th, 1960			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince George County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.				24a. REC'D BY REGISTRAR DATE MAR 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WESTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. HARRIS		45		Male		White		10-1-20	
PLACE OF DEATH		RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
Home		1234 N. Main St.		Carpenter		Myocardial Infarction		Natural	
LOCALITY		CITY		COUNTY		STATE		FEDERAL DISTRICT	
Baltimore		Baltimore		Anne Arundel		Maryland		District of Columbia	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF EXAMINER		TITLE OF EXAMINER	
10-1-20		10:00 AM		Home		J. H. Smith		Medical Examiner	
DATE OF BURIAL		TIME OF BURIAL		PLACE OF BURIAL		SIGNATURE OF CLERK		TITLE OF CLERK	
10-3-20		12:00 PM		Catholic Cemetery		A. B. Jones		Clerk	
DATE OF INTERMENT		TIME OF INTERMENT		PLACE OF INTERMENT		SIGNATURE OF MINISTER		TITLE OF MINISTER	
10-3-20		10:00 AM		Catholic Cemetery		P. Q. R.		Minister	

RECEIVED BY THE DEPARTMENT OF HEALTH

18-10-20

2328

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 63 Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James A. Ciotto				4. DATE OF DEATH Feb. 11 1960			
5. SEX M.		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-17-86	
9. AGE (In years lost birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef				10b. KIND OF BUSINESS OR INDUSTRY Hotel			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Vittoria Giannini			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No				16. SOCIAL SECURITY NO. Corinna G. Ciotto (Wife) Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes mellitus - 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes nephropathy DUE TO (c) Diabetes mellitus - 260X						INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb. 10 , 19 60 , to Feb. 11 , 19 60 , that I last saw the deceased alive on Feb. 11 , 19 60 , and that death occurred at 7:35 pm from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5510 Madison St. Riverdale, Md. DATE SIGNED Feb 17 '60							
ACTUAL SIGNATURE Dr. Albert Roth M.D.				DATE SIGNED Feb 17 '60			
PHYSICIAN'S NAME (Type) Dr. Albert Roth				DATE SIGNED Feb 17 '60			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 2/17/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				4739 Baltimore Ave. Hyattsville, Maryland			
24a. REC'D BY REGISTRAR FEB 17 '60				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CHURCH OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG256 2-15-60 et

2329

CERTIFICATE OF DEATH

Reg. Dist. No.

02323

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 7 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY District Of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1541 Brentwood Rd. N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Annie Clark		4. DATE OF DEATH Month Day Year Feb. 5 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1864 1865
9. AGE (In years lost birthday) 94 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ? Mangum		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hospital Records		Address Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) congestive heart failure DUE TO (c) a few days heart attack		INTERVAL BETWEEN ONSET AND DEATH 9 days 2 days year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 29th, 1960 to Feb. 5 , 1960 that I last saw the deceased alive on Feb. 4 , 1960, and that death occurred at 1:15 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Til Bergmann		ADDRESS (Street, city or town, state) Hyattsville, Md.	
PHYSICIAN'S NAME (Type) Til Bergmann		DATE SIGNED 2/6/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/8/60	
22c. NAME OF CEMETERY OR CREMATION Epithany Episcopal		22d. LOCATION (City, town, or county) (State) Forestville, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE FEB 9 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

12. Name of informant: [illegible]
13. Address of informant: [illegible]
14. Signature of informant: [illegible]
15. Date of completion: [illegible]
16. Registrar's office: [illegible]
17. County: [illegible]
18. State: [illegible]

2330

CERTIFICATE OF DEATH

Reg. Dist. No.

02324

1. PLACE OF DEATH a. COUNTY Prince Georges county MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 17 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle B. Last Clark				4. DATE OF DEATH Month Feb. Day 24 Year 19 60			
5. SEX Male		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-8-1873	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Lev Clark				14. MOTHER'S MAIDEN NAME /Frances Barnes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 578-03-2723			
17. INFORMANT Ann Clark Address Bowie, Maryland.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 22 Feb 1960							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to Feb. 24 1960 that I last saw the deceased alive on Feb. 24 1960 , and that death occurred at 6:50 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) E. Riverdale., Md DATE SIGNED 2-27-60 ACTUAL SIGNATURE Albert P. Roer M.D. PHYSICIAN'S NAME (Type) Dr. Albert Roth., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2/27/60 22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery 22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.							
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md. 24a. REC'D BY REGISTRAR DATE FEB 29 '60 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1330

ENTRANCE OF DEPT.

11:00 AM

11:00 AM

11:00 AM

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CERTIFICATE OF DEATH

Reg. Dist. No.

02325

2331

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville d. STREET ADDRESS 3206 Fairland Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Leonard Elwood Cochran Jr.				4. DATE OF DEATH Month Day Year Feb. 8 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-7-59	
9. AGE (In years last birthday) 3		10. IF UNDER 1 YEAR Months Days Hours Min. 3		11. IF UNDER 24 HRS. Months Days Hours Min. 3		12. IF UNDER 1 YEAR Months Days Hours Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Leonard E. Cochran Sr.				14. MOTHER'S MAIDEN NAME Mary Bell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		INFORMANT Leonard E. Cochran Sr	
17. ADDRESS Same as #2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 7544 DUE TO (b) Sub endocardial fibro elastosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 7, 1960 , to Feb. 8, 1960 , that I last saw the deceased alive on Feb. 8, 1960 , and that death occurred at 8:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 388 Montrose Ave, Laurel, Md. DATE SIGNED 2-9-60 ACTUAL SIGNATURE Albert J. Modlin M.D. PHYSICIAN'S NAME (Type) Albert J. Modlin							
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 2/10/60		22c. NAME OF CEMETERY OR CREMATORY Medow Ridge		22d. LOCATION (City, town, or county) (State) Dorsey, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				4739 Baltimore Ave. Hyattsville, Md.		24c. REC'D BY REGISTRAR FEB 11 1960	
24b. REGISTRAR'S SIGNATURE Arthur S. Knecht							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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2831

James Douglas

Chas. J.

James Douglas General

Elwood

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James F. Douglas Jr.

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James F. Douglas Jr.

James F. Douglas Jr.

U.S.A.

Motor Road

1759 Baltimore Ave.

Baltimore, Md.

James F. Douglas

James F. Douglas

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2332 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02326

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX Cheverly		c. LENGTH OF STAY IN 1b EXTENDED OA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS /			
3. NAME OF DECEASED (Type or print) First John Middle Wesley Last Condon				4. DATE OF DEATH Month February Day 19 Year 19 60			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan- 5- 1881		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done (If deceased was retired)) XXXX Laborer		10b. KIND OF BUSINESS OR INDUSTRY TENANT		11. BIRTHPLACE (State or foreign country) Maryland Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XXXX No		16. SOCIAL SECURITY NO. XXXXX		17. INFORMANT James Albert Condon; 5806 33rd Avenue W. Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2nd and 3rd degree burns of 20% Of body DUE TO (c) Acute myocardial failure							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiovascular renal disease							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Burned by flame from wood stove in home.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 2- 19 19 60 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Mitchellville Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/23/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) Lothian Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home—Marlboro, Md.				24a. REC'D BY REGISTRAR DATE MAR 1 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hana	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1992

1. The first group of people who are not in the labor force are those who are not in the labor force because they are not in the labor force.

2333 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2Hr			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Boy Middle Connor Last Connor				4. DATE OF DEATH Month Feb. Day 16 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 16, 1960	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Byron Eugene Connor				14. MOTHER'S MAIDEN NAME Florence Mine Serrier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
INFORMANT Mother				Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Resorption atelectasis 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb. 16 , 19 60 , to Feb. 16 , 19 60 , that I last saw the deceased alive on Feb. 16 , 19 60 , and that death occurred at 8:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Prince Georges General Hosp. Cheverly, Md. DATE SIGNED 2/16/60							
ACTUAL SIGNATURE Thomas A. Christensen M.D. Dr. Thomas A. Christensen M.D. Chesley, Sutterland							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 2/18/60		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn Jr. Administrator.				24a. REC'D BY REGISTRAR FEB 23 '60		24b. REGISTRAR'S SIGNATURE William J. H. H.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2334 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02328

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>07 Forestville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>8109 Marlboro Pike S.E.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Mortimer</u> Last <u>Cranford</u>							
4. DATE OF DEATH Month <u>February</u> Day <u>23</u> Year <u>1960</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>November 25/07</u>		9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Mortimer Clem Cranford</u>			14. MOTHER'S MAIDEN NAME <u>Ethel Westcamp</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>#709-12-4761</u>		17. INFORMANT <u>Carl E. Cranford, same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>							
DUE TO <u>420.1</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Cardiovascular renal disease</u>							
DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>February 23, 1960</u>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/26/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cem.</u>			
22d. LOCATION (City, town, or county) <u>Upper Marlboro, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Funeral Home-</u>		ADDRESS <u>Upper Marlboro, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 1 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 33A MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
SIGNATURE OF EXAMINER [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	
CERTIFICATE NO. [REDACTED]		COUNTY [REDACTED]		STATE [REDACTED]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02329

2399

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE DISTRICT OF COLUMBIA b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 2 DAYS 17 HRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C. 47X-3	
		d. STREET ADDRESS 310 61st STREET NE IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last M/B - DAWKINS		4. DATE OF DEATH Month Day Year FEB 22 1960	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 FEBRUARY 1960
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 2 17 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME SANFORD LOUIS DAWKINS		14. MOTHER'S MAIDEN NAME ANN MARIE JORDAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MEDICAL CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atelectasis (c) Immaturity		INTERVAL BETWEEN ONSET AND DEATH 15 minutes 65 hrs 59 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 February, 1960, to 22 February, 1960, that I last saw the deceased alive on 22 February, 1960, and that death occurred at 2:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John A. Moore M.D.		ADDRESS (Street, city or town, state) DATE SIGNED ANDREWS AIR FORCE BASE 22 FEBRUARY 1960	
PHYSICIAN'S NAME (Type) JOHN A. MOORE CAPT USAF MC		USAF HOSPITAL ANDREWS, WASHINGTON 25, DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-26-60		22b. DATE THEREOF 2-26-60	
22c. NAME OF CEMETERY OR CREMATORY Public Cemetery		22d. LOCATION (City, town, or county) (State) D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS	
24a. REC'D BY REGISTRAR DATE FEB 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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RECEIVED

FEB 24 12 00 PM '60

CORONER'S OFFICE D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2400 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 5, Allentown Road</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Camp Springs.</u> d. STREET ADDRESS <u>5961 Allentown Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>WARREN</u> <u>GEORGE</u> <u>DAY</u>				4. DATE OF DEATH Month Day Year <u>February</u> <u>10.</u> <u>19 60</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 3, 1891</u>		9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist Helper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.N. YARD</u>				11. BIRTHPLACE (State or foreign country) <u>Camp Springs, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Day</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Day</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>579-14-6412</u>				17. INFORMANT Address <u>6503 Allentown Camp Springs, Md. Rd.</u> <u>James M. Day</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage & Shock</u> DUE TO (b) <u>Fracture of Skull, Compound Comminuted fracture of the left tibia and fibula. Fracture of the left femur. Fracture of the right tibia and fibula</u> (c) <u>Fracture of the left femur. Fracture of the right tibia and fibula</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of the left femur. Fracture of the right tibia and fibula</u> INTERVAL BETWEEN ONSET AND DEATH											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>812x</u>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian struck by an automobile</u>					
20c. TIME OF INJURY Month, Day, Year <u>6:00 PM</u> <u>2/10/60</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road</u>		20f. (City or town) <u>Camp Springs, Md.</u>		20g. (State) <u>P. G. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James I. Boyd</u>						DATE SIGNED <u>February 11, 1960</u>					
EXAMINER'S NAME (Type) <u>JAMES I. BOYD, M.D.</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Feb 13-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bells Methodist</u>				22d. LOCATION (City, town, or county) <u>Camp Springs Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Summers Bros 1661-gd Hope Rd S E</u>						ADDRESS <u>Wash 20, DC</u>		24a. REC'D BY REGISTRAR <u>FEB 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
3800 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12-5-29		6. BIRTH PLACE MOBILE, ALA.	
7. OCCUPATION None		8. MARITAL STATUS Single		9. EDUCATION High School	
10. PRESENT ADDRESS Room 303, 215 North E. Street, Baltimore, Md.		11. DATE OF DEATH 4-4-68		12. TIME OF DEATH 11:00 AM	
13. PLACE OF DEATH Room 303, 215 North E. Street, Baltimore, Md.		14. CAUSE OF DEATH Suicide by gunshot		15. MANNER OF DEATH Homicide	
16. SIGNATURE OF EXAMINER J. Edgar Hoover		17. SIGNATURE OF DECEASED James Earl Ray		18. SIGNATURE OF WITNESS John Edgar Hoover	
19. SIGNATURE OF WITNESS John Edgar Hoover		20. SIGNATURE OF WITNESS John Edgar Hoover		21. SIGNATURE OF WITNESS John Edgar Hoover	
22. SIGNATURE OF WITNESS John Edgar Hoover		23. SIGNATURE OF WITNESS John Edgar Hoover		24. SIGNATURE OF WITNESS John Edgar Hoover	
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70. SIGNATURE OF WITNESS John Edgar Hoover		71. SIGNATURE OF WITNESS John Edgar Hoover		72. SIGNATURE OF WITNESS John Edgar Hoover	
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82. SIGNATURE OF WITNESS John Edgar Hoover		83. SIGNATURE OF WITNESS John Edgar Hoover		84. SIGNATURE OF WITNESS John Edgar Hoover	
85. SIGNATURE OF WITNESS John Edgar Hoover		86. SIGNATURE OF WITNESS John Edgar Hoover		87. SIGNATURE OF WITNESS John Edgar Hoover	
88. SIGNATURE OF WITNESS John Edgar Hoover		89. SIGNATURE OF WITNESS John Edgar Hoover		90. SIGNATURE OF WITNESS John Edgar Hoover	
91. SIGNATURE OF WITNESS John Edgar Hoover		92. SIGNATURE OF WITNESS John Edgar Hoover		93. SIGNATURE OF WITNESS John Edgar Hoover	
94. SIGNATURE OF WITNESS John Edgar Hoover		95. SIGNATURE OF WITNESS John Edgar Hoover		96. SIGNATURE OF WITNESS John Edgar Hoover	
97. SIGNATURE OF WITNESS John Edgar Hoover		98. SIGNATURE OF WITNESS John Edgar Hoover		99. SIGNATURE OF WITNESS John Edgar Hoover	
100. SIGNATURE OF WITNESS John Edgar Hoover		101. SIGNATURE OF WITNESS John Edgar Hoover		102. SIGNATURE OF WITNESS John Edgar Hoover	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 1,7 Film G256 2-15-60 et
CERTIFICATE OF DEATH

Reg. Dist. No.

12331

2304

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>NEBRASKA</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				c. LENGTH OF STAY IN 1b <u>2 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BLAIR</u> <u>64X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6907 40th Ave Private Res.</u>				d. STREET ADDRESS <u>2166 Washington St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ennice MAY Dixon</u>				4. DATE OF DEATH Month Day Year <u>Feb 8 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 14 1883</u>	
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James Kehoe</u>				14. MOTHER'S MAIDEN NAME <u>Flora Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Informant</u>			
17. ADDRESS <u>Mrs Ennice Murray Hyattsville Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS, ACUTE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE 5 yrs.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>JAN 4</u> , 19 <u>60</u> , to <u>FEB 8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>FEB 3</u> , 19 <u>60</u> , and that death occurred at <u>12:55</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Comeau</u> M.D.				ADDRESS (Street, city or town, state) <u>3503 Perry St</u> DATE SIGNED <u>2/8/60</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMEAU MD. MT PAINIER MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit to Blair</u>				22b. DATE THEREOF <u>2/8/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Blair</u>	
22d. LOCATION (City, town, or county) (State) <u>Nebraska</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Caschione Hyattsville Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Finner</u>	

11

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June 1st

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2401

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn		c. LENGTH OF STAY IN 1b transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5701 Berwyn Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Melvin Dodson		4. DATE OF DEATH Month February Day 25 Year 1960	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-37
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min.	IF UNDER 24 HRS. Hours 22 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Albert Dodson		14. MOTHER'S MAIDEN NAME Bertha Virginia Bailey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-32-4309	
17. INFORMANT Carole Ruth Dodson; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 981x DUE TO Conditions, if any, which gave rise to immediate cause (b) Gunshot wound of chest (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by another person.	
20c. TIME OF DEATH Month, Day, Year Feb. 25, 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Store		20f. (City or town) (County) (State) Berwyn Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED February 25, 1960	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/60	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE FEB 29 '60		24b. REGISTRAR'S SIGNATURE Carole Ruth Dodson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02333

2402

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aguasco</u>				c. LENGTH OF STAY IN 1b <u>X Aguasco</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henrietta Nelson Douglas</u>				4. DATE OF DEATH Month Day Year <u>Feb. 13 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 18, 1957</u>	9. AGE (In years, lost birthday) yrs. <u>2</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Nelson Wood Land</u>				14. MOTHER'S M maiden NAME <u>Henrietta Douglas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Henrietta Douglas, Aguasco, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>malnutrition</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Feb. 13, 1960</u> , to <u>19</u> , that I last saw the deceased alive on <u>Feb. 13, 1960</u> , and that death occurred at <u>5 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Bryantown, Md.</u> ACTUAL SIGNATURE <u>Harry R. Coburn</u> M.D. <u>Bryantown, Md.</u> PHYSICIAN'S NAME (Type) <u>Harry R. Coburn, M.D.</u> <u>Bryantown, Maryland.</u> <u>AGUASCO</u> (State)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)	
<u>Burial</u>		<u>Feb. 16, 1960</u>		<u>St. Philips</u>		<u>AGUASCO, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton E. Kraus</u>	

CERTIFICATE OF DEATH

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Prince George

Prince George

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2335 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Stephen Middle Michael Last Dunphy		4. DATE OF DEATH Month Feb Day 8 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 Feb 1960
9. AGE (In years last birthday) yrs. 4		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 8 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Child	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas F. Dunphy Sr.		14. MOTHER'S MAIDEN NAME Melva Milstead	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Thomas F. Dunphy		Address 7715 Oxman Rd., Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atelectasis 762.5 DUE TO Pneumaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-3 , 19 60 , to 2-7 , 19 60 , that I last saw the deceased alive on 2-7 , 19 60 , and that death occurred at 12,45A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Hans Wodak		DATE SIGNED 30-C Bridge Rd. Greenbelt, Md. 2-8-60	
PHYSICIAN'S NAME (Type) Dr. Hans Wodak., MD		30-C Bridge Rd., Greenbelt, Md. 2/8/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 11, 1960	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Md.		24a. REC'D BY REGISTRAR FEB 10 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

1
3
M
077
1
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

2077223XV2

STATE OF TEXAS
COUNTY OF DALLAS

Know all men by these presents, that _____ of the County of _____ State of _____

do hereby certify that _____

is the true and correct copy of the _____

_____ of the _____

_____ of the _____

_____ of the _____

_____ of the _____

_____ of the _____

Handwritten signature

2403

CERTIFICATE OF DEATH

02335

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berksire Md</u>				c. LENGTH OF STAY IN 1b <u>For years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7306 Hansford St SE, DC 28</u>				d. STREET ADDRESS <u>7306 Hansford St SE, DC 28</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Bridget</u> Middle <u>Agnes</u> Last <u>Fannon</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4 1879</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.		IF UNDER 24 HRS. Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Richard Fannon</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Cuff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mary Thurnice</u> Address <u>7306 Hansford St SE, Washington DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic Arteriosclerotic Hypertension</u> DUE TO (c) <u>General Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis non Specific and Spinal Arthritis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>natural causes</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____				20g. (County) _____		20h. (State) _____	
21. I certify that I attended the deceased from <u>April 4, 1950</u> , to <u>Feb 2, 1960</u> , that I last saw the deceased alive on <u>Feb 1, 1960</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Paul C Van Natta</u> M.D. <u>5-440 Silver Hill Rd SE</u>							
PHYSICIAN'S NAME (Type) <u>PAUL C VAN NATTA</u> <u>Washington DC</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-5-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Wash D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R Mattingly</u> ADDRESS <u>131-11 SE</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Clinton S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2403

Form 100-100

DECEASED'S NAME		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 1, 1900	
AGE		SEX	
65		Male	
RACE		RELIGION	
White		Roman Catholic	
BIRTHPLACE		NATURALIZATION	
New York		Naturalized	
MARRIAGE		EDUCATION	
Married		High School	
OCCUPATION		CAUSE OF DEATH	
Carpenter		Heart Disease	
PLACE OF DEATH		MANNER OF DEATH	
Home		Natural	
CERTIFICATE OF DEATH		SIGNATURE OF DECEASED'S NEAREST RELATIVE	
JAMES H. HARRIS		JAMES H. HARRIS	
DATE		DATE	
JANUARY 1, 1900		JANUARY 1, 1900	

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE.

2335 CERTIFICATE OF DEATH

02336

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY PrinceGeorge			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 West Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 1 911 Karlson Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph C Fish				4. DATE OF DEATH Month Day Year Feb 15 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 July 1880		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY XXXXXX		11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Fish				14. MOTHER'S MAIDEN NAME Mary Lord			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address Miss Florence Fish same as above.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO GASTRO INTESTINAL hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Esophageal Varices (c) Einnhosis OF LIVER							INTERVAL BETWEEN ONSET AND DEATH 48 hrs 1 mos 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1959, to Feb 15, 1960, that I last saw the deceased alive on Feb 15, 1960, and that death occurred at 6:30 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Dine		M.D. 3503 Pine St.		DATE SIGNED 2/15/60			
PHYSICIAN'S NAME (Type) Dr. Norman Comeau, M.D.		Mt. Rainier., Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-60		22c. NAME OF CEMETERY OR CREMATORY Congressional		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE J W LEE 300 4th St NE DC				24a. REC'D BY REGISTRAR DATE FEB 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2333

James George

Cherry

James George (James) Hamilton

Joseph

John

William

Joseph (John) Hamilton

Miss Florence (John) Hamilton

Part 1 2-1-50 (James) Hamilton

CERTIFICATE OF DEATH

Reg. Dist. No.

02337

2305

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY Washington, D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home		d. STREET ADDRESS 1701 H St. N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ida Jane Ford		4. DATE OF DEATH Month Feb Day 26 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/9/79
9. AGE (In years last birthday) 81		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government Clerk		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milton Ford		14. MOTHER'S MAIDEN NAME Mary Catherine VanHopping	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Home Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Disease- 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease- DUE TO (c) 11 years-		INTERVAL BETWEEN ONSET AND DEATH 5 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/7/49 , 19____, to 2/26/1960 , 19____, that I last saw the deceased alive on 2/25/1960 , 19____, and that death occurred at 1:45A , M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F. Collins M.D.		ADDRESS (Street, city or town, state) 322- H. Street, N.E.-2/26/60 DATE SIGNED	
PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.		Washington 2, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/29/60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR DATE FEB 29 60	
2901 14th St. N.W. Washington 9, D.C.		24b. REGISTRAR'S SIGNATURE Arthur L. Kincaid	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Prison George

Residence

George Henry Ford

2014 Avenue 10th St.

18a Jane

Female White

Government of Ohio

1100 1st St.

no name

Cooperative Hand Wagon

Archaeological Hand Wagon

1100 1st St.

2/2/1940

James F. Collins, N.Y.

Residence 2, N.Y.

2/2/1940

James F. Collins, N.Y.

2/2/1940

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02338

2404

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>T. B.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X + B</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dr. Williams Hospital</u>				d. STREET ADDRESS <u>Route #2 Brandywine</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Everette</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 19, 1958</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>1</u> Days <u>15</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Green</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mr. John Green, same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-16-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Piscataway, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR <u>Feb 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

100-21-5-2012

18. The following are the names of the persons who have been appointed to the various committees of the Board of Directors:

Dr. J. H. H. H. H.

2337 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 22 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 71 Hyattsville d. STREET ADDRESS 4106 Clagett Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leah Middle Greenberg Last Greenberg		4. DATE OF DEATH Month Feb. Day 7 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 11, 1909
9. AGE (In years last birthday) 50		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESIDENT UNITED AUTO CORP.	11. BIRTHPLACE (State or foreign country) PITTSBURGH PA
12. CITIZEN OF WHAT COUNTRY? U. S A		13. FATHER'S NAME DAVID COHEN	
14. MOTHER'S MAIDEN NAME ANNA PERLMAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NO		17. INFORMANT HOWARD ROBIN Address 2102 WESTVIEW TERR. SSM.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute lymphocytic Leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-4 , 19 56 , to 2-7 , 19 60 , that I last saw the deceased alive on 2-2 , 19 60 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Deitz		ADDRESS (Street, city or town, state) Hoffville, Pa.	
PHYSICIAN'S NAME (Type) Dr. A. Deitz		DATE SIGNED 2-7-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF FEB. 9, 1960	22c. NAME OF CEMETERY OR CREMATORY BETH SHALOM CEMETERY	22d. LOCATION (City, town, or county) (State) PITTSBURGH PA.
23. FUNERAL DIRECTOR'S SIGNATURE B. Dargatzis & Sons		ADDRESS 3501-14 St. NW	
24a. REC'D BY REGISTRAR FEB 10 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

02340

2405

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>PR. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>20 SUITLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>112- Belle Green ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD M. Grigsby</u>		4. DATE OF DEATH Month Day Year <u>Feb 21 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25-1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Cauley Grigsby</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET PAYNE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Mrs. Gertrude Mincar</u> Address <u>2901- BRANCH AVE. SE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>General Visceral Failure.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease.</u> (c) <u>Arteriosclerosis Generalized Advanced.</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 months.</u> <u>1 yr.</u> <u>5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-26, 1959</u> , to <u>2-21, 1960</u> that I last saw the deceased alive on <u>2-20, 1960</u> , and that death occurred at <u>8 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3801 Smith Rd. A. D. C. Wash. D. C.</u> DATE SIGNED <u>2-21-60</u> ACTUAL SIGNATURE <u>John J. Calhara</u> M.D. PHYSICIAN'S NAME (Type) <u>John J. Calhara M.D.</u> Wash. D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2-24-60</u>	<u>Ft. Lincoln</u>	<u>Blacksburg MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>		24a. REC'D BY REGISTRAR ADDRESS <u>1661- Good Hope Rd SE Wash D.C.</u> DATE <u>FEB 23 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CENTRAL OFFICE OF DEATH

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[Faint, illegible text and markings on a form, possibly a death certificate or official document. The text is mirrored and difficult to decipher.]



2338 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle C. Last Guiler				4. DATE OF DEATH Month Feb. Day 20 Year 19 60			
5. SEX Fem		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-29-09	
9. AGE (In years last birthday) 50		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Harvey M Guiler		14. MOTHER'S MAIDEN NAME Ida Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Martha G Ames Hyattsville Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Failure 526x DUE TO Absence of at. Lung, old, surgical Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Branchiectasis & Bronchopneumonia DUE TO (c) Agel.						INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 10 yrs. Agel.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 2nd , 19 66 , to Feb 20th , 19 60 , that I last saw the deceased alive on Feb 20th , 19 60 , and that death occurred at 2:05 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Deitz T. Bergeman M.D.				ADDRESS (Street, city or town, state) Hyattsville Md DATE SIGNED 2/20/60			
PHYSICIAN'S NAME (Type) Dr. Bergeman				Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 2/22/60		22c. NAME OF CEMETERY OR CREMATORY Quaker City		22d. LOCATION (City, town, or county) (State) Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland.				24a. REC'D BY REGISTRAR FEB 23 60		24b. REGISTRAR'S SIGNATURE John S. Kruer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film 6250 3/21/60 1b

CERTIFICATE OF DEATH

Reg. Dist. No.

02342

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u> <u>Hospital Center</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4408 Beach Drive, Wash.D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Non-Profit's Home 6905 Ager Road</u>		d. STREET ADDRESS <u>47X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Betty</u> Middle <u>ANN</u> Last <u>HABIB</u>		4. DATE OF DEATH Month <u>2</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/17/59</u>
9. AGE (In years last birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>28</u> Hours <u>19</u> Min. <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, DC</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Moee Habib</u>		14. MOTHER'S MAIDEN NAME <u>Reuben Joseph</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Nursing Home</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus (internal)</u> <u>752x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Birth on</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 1, 1960</u> to <u>2/28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/28/60</u> , 19 <u>60</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.		ADDRESS (Street, city or town, state) <u>6905 Bells Blvd</u> DATE SIGNED <u>2/29/60</u>	
PHYSICIAN'S NAME (Type) <u>Thomas A. Christensen MD</u>		<u>Coe Logo Park</u> <u>MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 8, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Michael J. Rinaldi</u> ADDRESS <u>Rinaldi Funeral Home, Inc. 816 H St. NE, Wash., DC</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 7 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

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John H. H. H.

Hydrographic (continued)

1890/1891

John H. H. H. H.

John H. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2339 *Hammond - see Birth cert - Md.*
CERTIFICATE OF DEATH

Reg. Dist. No.

02343

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy		4. DATE OF DEATH HAMMOND Month Feb. Day 29 Year 19 60	
5. SEX Male	6. COLOR OR RACE B/	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-60
9. AGE (In years lost birthday) 2da.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harold Robert Hammond		14. MOTHER'S MAIDEN NAME Virginia Doris Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMATION Hospital records		Address Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 760.5 DUE TO Immaturity (Length=36cm, Weight=700gm.) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atelectasis (c) atelectasis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) atelectasis		INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 27 , 19 60 to Feb. 29 , 1960, that I last saw the deceased alive on Feb. 29 , 19 60 , and that death occurred at 8:30pm. from the causes and on the date stated above.			
ACTUAL SIGNATURE B. Van Geldren		ADDRESS (Street, city or town, state) 3001 Cheverly Ave. Cheverly Md.	
PHYSICIAN'S NAME (Type) Dr. B. Van Geldren		DATE SIGNED 3001 Cheverly Ave. Cheverly, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/60	
22c. NAME OF CEMETERY OR CREMATORY Evergreen		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE MAR 7 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Krawe			

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CERTIFICATE OF DEATH

02344

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write <u>LAUREL</u> and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write <u>LAUREL</u> and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>LAUREL SANITARIUM</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LEVINA</u> First <u>M.</u> Middle <u>HANCE</u> Last		4. DATE OF DEATH Month <u>Feb.</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 29, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JESSE HANCE</u>	
14. MOTHER'S MAIDEN NAME <u>MARK FEASEY</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>	
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Hospital Records LAUREL SANITARIUM</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X</u> DUE TO <u>Apoplexy (33i)</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>CEREBRAL ARTERIO-SCLEROSIS</u> DUE TO (c) <u>SEVERAL</u> <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>SEVERAL</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured left hip, operated on Jan. 22-1960</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-2-</u> , 19 <u>58</u> , to <u>2-2-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-2-</u> , 19 <u>60</u> , and that death occurred at <u>3:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Erika P. Kraemer</u> M.D.		ADDRESS (Street, city or town, state) <u>LAUREL SANITARIUM 2-1-60</u>	
PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER</u>		<u>LAUREL MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE, THEREOF <u>2/4/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>IVY HILL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>LAUREL MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Donaldson Laurel Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 8 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>W. S. Thoms</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5371

DECEASED
NAME
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
PLACE OF DEATH
DATE OF DEATH
SIGNATURE
DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

2383

Item 7 Film G256 2-11-60 et

CERTIFICATE OF DEATH

02345

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 17 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 45 Riverdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital			d. STREET ADDRESS 4711 Sheridan Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANNA Middle R. Last HANEY		4. DATE OF DEATH Month 2/ Day 5 Year 19 60			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/82	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 19 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Connecticut	
13. FATHER'S NAME John Hall Morse			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. MOTHER'S MAIDEN NAME Belle Goodwin					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Upper respiratory infection					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. 3:30 p. m. 1/19/60 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Riverdale	(County) Pr. Geo. (State) Md.
21. I certify that I attended the deceased from _____, 19____, to 2-5 , 19 60 , that I last saw the deceased alive on 2-5 , 19 60 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4408 Queensbury Road DATE SIGNED 2/5/60					
ACTUAL SIGNATURE D.R. Purdie		M.D. 4408 Queensbury Road			
PHYSICIAN'S NAME (Type) D.R. Purdie, M.D.		Riverdale, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb 9, 1960	22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE FEB 9 '60
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SERVICE		12. PLACE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	
JAMES J. JONES		Male		45		1880		New York		Teacher		Married		White		Roman Catholic		High School		None		Home		Jan 15, 1920		10:30 AM		Heart Disease		Natural		J. J. Jones		J. J. Jones		J. J. Jones			
21. PLACE OF INTERMENT		22. NAME OF INTERMENT		23. DATE OF INTERMENT		24. TIME OF INTERMENT		25. PLACE OF INTERMENT		26. NAME OF INTERMENT		27. DATE OF INTERMENT		28. TIME OF INTERMENT		29. PLACE OF INTERMENT		30. NAME OF INTERMENT		31. DATE OF INTERMENT		32. TIME OF INTERMENT		33. PLACE OF INTERMENT		34. NAME OF INTERMENT		35. DATE OF INTERMENT		36. TIME OF INTERMENT		37. PLACE OF INTERMENT		38. NAME OF INTERMENT		39. DATE OF INTERMENT		40. TIME OF INTERMENT	
St. James Cemetery		St. James Cemetery		Jan 15, 1920		10:30 AM		St. James Cemetery		St. James Cemetery		Jan 15, 1920		10:30 AM		St. James Cemetery		St. James Cemetery		Jan 15, 1920		10:30 AM		St. James Cemetery		St. James Cemetery		Jan 15, 1920		10:30 AM		St. James Cemetery		St. James Cemetery		Jan 15, 1920		10:30 AM	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. COLOR

9. RELIGION

10. EDUCATION

11. SERVICE

12. PLACE OF DEATH

13. DATE OF DEATH

14. TIME OF DEATH

15. CAUSE OF DEATH

16. MANNER OF DEATH

17. SIGNATURE OF PHYSICIAN

18. SIGNATURE OF REGISTRAR

19. SIGNATURE OF WITNESSES

20. SIGNATURE OF DECEASED

21. PLACE OF INTERMENT

22. NAME OF INTERMENT

23. DATE OF INTERMENT

24. TIME OF INTERMENT

25. PLACE OF INTERMENT

26. NAME OF INTERMENT

27. DATE OF INTERMENT

28. TIME OF INTERMENT

29. PLACE OF INTERMENT

30. NAME OF INTERMENT

31. DATE OF INTERMENT

32. TIME OF INTERMENT

33. PLACE OF INTERMENT

34. NAME OF INTERMENT

35. DATE OF INTERMENT

36. TIME OF INTERMENT

37. PLACE OF INTERMENT

38. NAME OF INTERMENT

39. DATE OF INTERMENT

40. TIME OF INTERMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2378

CERTIFICATE OF DEATH

Reg. Dist. No.

02346

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) of STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL SANITARIUM</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GERTRUDE</u> Middle <u>R.</u> Last <u>HANNAH</u>		4. DATE OF DEATH Month <u>9</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 7-1874</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>not any</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>A. RICHARDS</u>		14. MOTHER'S MAIDEN NAME <u>MARK GOCHROVE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>not known</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Hosp. Records LAUREL SANITARIUM</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (493)</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Apoplexy</u> (c) <u>cerebral arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile psychosis</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Several days</u> <u>Several weeks</u> <u>many years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>36</u> , to <u>2-5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-5-</u> 19 <u>60</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lillian P. Kraemer</u>		ADDRESS (Street, city or town, state) <u>LAUREL SANITARIUM</u> DATE SIGNED <u>2-5-60</u>	
PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER</u>		<u>LAUREL MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb 9, 1960</u>		22b. DATE THEREOF <u>Feb 9, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. W. H. [illegible]</u>		24a. REC'D BY REGISTRAR <u>FEB 10 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. [illegible]</u>	

5828

CERTIFICATE OF DEATH

1

2

STATE OF NEW YORK

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5,6,7 Film G257 2-29-60 et

2400

CERTIFICATE OF DEATH

02347

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HUNTSVILLE</u>	c. LENGTH OF STAY IN 1b <u>1 yr</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X HUNTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>THOMAS HARROD</u>		4. DATE OF DEATH <u>Feb 18</u> 19 <u>60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 3. 1880</u> 79
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Care taker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cemetery</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ROBERT HARROD</u>	
14. MOTHER'S MAIDEN NAME <u>MATILDA CRAWFORD</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>NO</u>		INFORMANT Address <u>Mrs. Elsie JACKSON - Daughter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSION</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT. 17, 19 49</u> to <u>FEB. 18, 19 60</u> that I last saw the deceased alive on <u>FEB. 17, 19 60</u> , and that death occurred at <u>11:45 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. C. Beldon</u>		M.D. <u>4423 - HUNT - PL. NE, 19</u>	
PHYSICIAN'S NAME (Type) <u>H. C. BELDON</u>		<u>Wash. D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/24/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ridgeley Meth. Church Cemo.</u>		22d. LOCATION (City, town, or county) (State) <u>St. Pleasant, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Stewart</u>		24a. REC'D BY REGISTRAR <u>FEB 24 60</u>	
ADDRESS <u>30 H Street, N.E.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2407

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02348

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi		c. LENGTH OF STAY IN 1b transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings		04X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7901 Kreeger Drive				d. STREET ADDRESS Route # 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles William Harvey				4. DATE OF DEATH February 16 19 60			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-11-02	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Biggs Harvey				14. MOTHER'S MAIDEN NAME Ida Holland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-12-4944		17. INFORMANT Ruth Alba Harvey; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 912.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple lacerations of abdomen, pelvis DUE TO (c) and legs and contents of each.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) A broken shovel cable caused a back hoe to drop, pinning deceased against a 6" pipe.					
20c. TIME OF INJURY Month, Day, Year 8.25 PM 2-16- 19 60		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Adelphi (County) Pr. Geo. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED Feb. 16, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/60		22c. NAME OF CEMETERY OR CREMATORY Rehaboth Church Cem.		22d. LOCATION (City, town, or county) Owings Cal. Co. Ind. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Erroy C. Berry				24a. REC'D BY REGISTRAR FEB 23 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G258 3/11/60 iwk

02349

2408

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside Md		c. LENGTH OF STAY IN lb 26 Hillside Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1302 53rd avenue		d. STREET ADDRESS 1302 53rd avenue,.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle O DELL Last HARVEY		4. DATE OF DEATH Month February Day 29 , Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 7, 1889 1888
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Construction work	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Norval C Harvey		14. MOTHER'S MAIDEN NAME Mary A Beall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW I		16. SOCIAL SECURITY NO. 579 12 7553	
INFORMANT Mary Harvey		Address Hillside, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cor pulmonale (c) Obstructive emphysema		INTERVAL BETWEEN ONSET AND DEATH 10 Minutes 3 years 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO PRETERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-16- , 19 57 , to 2-28- , 19 60 , that I last saw the deceased alive on 2-10- , 19 60 , and that death occurred at 11:50P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter Dunn		ADDRESS (Street, city or town, state) 6124 Central Av	
PHYSICIAN'S NAME (Type) PETER DUNN		DATE SIGNED 2/29/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 3, 1960	
22c. NAME OF CEMETERY OR CREMATOR Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland	
24a. REC'D BY REGISTRAR MAR 3 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2340

CERTIFICATE OF DEATH

02350

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3512 56th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EUGENE HAUXHURST		4. DATE OF DEATH Month Day Year Feb. 16, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1899
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY D. C. Government	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Eugene N. Hauxhurst	
14. MOTHER'S MAIDEN NAME Bertha Larabee		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Anne D. Hauxhurst (Wife) Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY THROMBOSIS DUE TO (b) ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from DEC. 23, 1959, to FEB. 16, 1960, that I last saw the deceased alive on FEBRUARY 16, 1960, and that death occurred at 7:15 A.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Till Bergemann		ADDRESS (Street, city or town, state) 4314 GALLATIN ST. HYATTSVILLE, MD.	
DATE SIGNED 2-17-60		PHYSICIAN'S NAME (Type) TILL BERGEMANN, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/19/60	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county): (State) Suitland Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		4739 Baltimore Ave. Hyattsville, Maryland	
24a. REC'D BY REGISTRAR DATE FEB 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2371 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02351

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u> c. LENGTH OF STAY IN 1b <u>8 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7109 Cabot Street</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23 District Heights</u> d. STREET ADDRESS <u>7109 Cabot Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Josephine Bateler Hayer</u> First Middle Last				4. DATE OF DEATH <u>Feb 16</u> 19 <u>60</u> Month Day Year											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 31, 1883</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Run Home</u>				11. BIRTHPLACE (State or foreign country) <u>District Columbia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Zachary T. Bateler</u>						14. MOTHER'S MAIDEN NAME <u>Hester Tanner</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Helen Moore</u> <u>Same as #2</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular renal disease</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid arthritis - Grippie</u>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item-18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <u>Feb 16, 1960</u>									
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-19-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>				22d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Summers Bros</u> ADDRESS <u>1661 - Good Hope Rd SE Wash DC</u>						24a. REC'D BY REGISTRAR DATE <u>FEB 17 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

337 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED (Print name in full)		SEX (Male or Female)		AGE (In years and months)	
RACE (Print race)		BIRTH DATE (Print date)		PLACE OF BIRTH (Print place)	
OCCUPATION (Print occupation)		MARITAL STATUS (Print status)		PLACE OF DEATH (Print place)	
TIME OF DEATH (Print time)		DATE OF DEATH (Print date)		TIME OF EXAMINATION (Print time)	
SIGNATURE OF DECEASED (Print signature)		SIGNATURE OF WITNESS (Print signature)		SIGNATURE OF EXAMINER (Print signature)	
ADDRESS OF DECEASED (Print address)		ADDRESS OF WITNESS (Print address)		ADDRESS OF EXAMINER (Print address)	
CITY OF DECEASED (Print city)		CITY OF WITNESS (Print city)		CITY OF EXAMINER (Print city)	
STATE OF DECEASED (Print state)		STATE OF WITNESS (Print state)		STATE OF EXAMINER (Print state)	
COUNTY OF DECEASED (Print county)		COUNTY OF WITNESS (Print county)		COUNTY OF EXAMINER (Print county)	
ZIP CODE OF DECEASED (Print ZIP code)		ZIP CODE OF WITNESS (Print ZIP code)		ZIP CODE OF EXAMINER (Print ZIP code)	
PHONE NUMBER OF DECEASED (Print phone number)		PHONE NUMBER OF WITNESS (Print phone number)		PHONE NUMBER OF EXAMINER (Print phone number)	
SIGNATURE OF DECEASED (Print signature)		SIGNATURE OF WITNESS (Print signature)		SIGNATURE OF EXAMINER (Print signature)	
ADDRESS OF DECEASED (Print address)		ADDRESS OF WITNESS (Print address)		ADDRESS OF EXAMINER (Print address)	
CITY OF DECEASED (Print city)		CITY OF WITNESS (Print city)		CITY OF EXAMINER (Print city)	
STATE OF DECEASED (Print state)		STATE OF WITNESS (Print state)		STATE OF EXAMINER (Print state)	
COUNTY OF DECEASED (Print county)		COUNTY OF WITNESS (Print county)		COUNTY OF EXAMINER (Print county)	
ZIP CODE OF DECEASED (Print ZIP code)		ZIP CODE OF WITNESS (Print ZIP code)		ZIP CODE OF EXAMINER (Print ZIP code)	
PHONE NUMBER OF DECEASED (Print phone number)		PHONE NUMBER OF WITNESS (Print phone number)		PHONE NUMBER OF EXAMINER (Print phone number)	

2409

CERTIFICATE OF DEATH

Reg. Dist. No.

02352

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>				c. LENGTH OF STAY IN 1b. <u>10 Months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9512 WORRELL AVE</u>				d. STREET ADDRESS <u>9512 Worrell Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Effie Browning Hering</u>				4. DATE OF DEATH Month Day Year <u>Feb. 29 1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29 1884</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horsewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>WILLIAM S. BROWNING</u>				14. MOTHER'S MAIDEN NAME <u>SARAH E. GOHEENS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
INFORMANT Address <u>9512 Worrell Ave</u>				Mrs Marjorie Hering Lanham, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Insufficiency</u> DUE TO (c) <u>Hypertensive Cardio-vascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 Months</u> <u>2 Yrs.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4 Jan.</u> , 19 <u>60</u> , to <u>29 Feb.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>15 Feb.</u> , 19 <u>60</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thos. M. Hutchins</u>				ADDRESS (Street, city or town, state) <u>7315 Landover Rd. Hyattsville, Md.</u>			
DATE SIGNED <u>2-29-60</u>							
PHYSICIAN'S NAME (Type) <u>THOMAS M. HUTCHINS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-2-1960</u>		<u>Prospect Hill Cem</u>		<u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers & Co. Riverdale, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of said County, at the City of Dallas, this 1st day of January, 1901.

Attest:
County Clerk

Witness my hand and the seal of said County, at the City of Dallas, this 1st day of January, 1901.

Notary Public

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02353

2372

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>Pr. Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>District Hghts</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>23 District Hghts</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3307-Roslyn St</i>		d. STREET ADDRESS <i>1 3307-Roslyn St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>R.</i> Last <i>Hicks JR</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>20</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 6 - 1945</i>
9. AGE (In years last birthday) <i>14</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John R. Hicks Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Margaret M. Cusick</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>INFORMANT</i>	
17. ADDRESS <i>John R. Hicks Sr. 3307-Roslyn St Dist Hghts, md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic visceral failure</i> 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral degeneration</i> DUE TO (c) <i>Hydrocephalus with meningomyelocel</i>		INTERVAL BETWEEN ONSET AND DEATH <i>several mos.</i> " <i>birth</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1/5, 1955</i> , to <i>2/20, 1960</i> , that I last saw the deceased alive on <i>1/14, 1960</i> , and that death occurred at <i>8:00 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Louis L. Cross</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>5556 Silver Hill Rd., S.E. 2-20-60</i>	
PHYSICIAN'S NAME (Type) <i>Louis L. Cross</i>		Washington 28, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-22-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) (State) <i>md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Simmons Bros.</i>		ADDRESS <i>1661-Cood Hope Rd WASH 20 125</i>	
24a. REC'D BY REGISTRAR DATE <i>FEB 23 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

CERTIFICATE OF DEATH

2272

Blank certificate form with faint lines and text for recording death information.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2341 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02354

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Glen Arden			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1st and Lincoln Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Timothy Middle Rogers Last Holmes				4. DATE OF DEATH Month February Day 27 Year 19 60			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1958		9. AGE (In years last birthday) 1 yrs.	IF UNDER 1 YEAR Months 1 Days 1	IF UNDER 24 HRS. Hours 1 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alphonsoe Nathaniel Holmes				14. MOTHER'S MAIDEN NAME Delores Holmes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Delores Holmes; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		February 27, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3-2-60		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Bonning Rd S.E.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington				ADDRESS 4925 Deane Ave NE		24a. REC'D BY REGISTRAR DATE MAR 8 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02355

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook		c. LENGTH OF STAY IN 1b transient									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pennsylvania R.R. Tracks		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Helen Middle Louise Last Hopkins		4. DATE OF DEATH Month February Day 5 Year 19 60									
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-20-40								
9. AGE (In years last birthday) 20 yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
10b. KIND OF BUSINESS OR INDUSTRY Mercantile		11. BIRTHPLACE (State or foreign country) D.C.									
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Hopkins									
14. MOTHER'S MAIDEN NAME Mary Louise Ridgeway		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.									
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Albert Ridgeway; Glen Dale, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Trauma; multiple and severe DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Riding in an automobile which was struck by a train.									
20c. TIME OF INJURY Month, Day, Year 10.36 P. M. 2-5-60 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) R.R. Tracks		20f. (City or town) (County) (State) Seabrook Pr. Geo. Md.									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.											
ACTUAL SIGNATURE <i>John T. Maloney</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, or other disposition Burial		22b. DATE THEREOF 2/9/60									
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.									
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE FEB 11 '60									
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>		DATE SIGNED February 6, 1960									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 15, 1950		Home	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Time of Death		Place of Death		Name of Physician		Signature of Physician		Signature of Medical Examiner	
10:00 AM		Home		Dr. J. Smith		[Signature]		[Signature]	
Date of Birth		Date of Death		Date of Examination		Date of Report		Date of Filing	
Jan 1, 1905		Jan 15, 1950		Jan 16, 1950		Jan 16, 1950		Jan 16, 1950	
Place of Birth		Place of Death		Place of Examination		Place of Report		Place of Filing	
New York		Home		Baltimore		Baltimore		Baltimore	
Marital Status		Social Status		Economic Status		Educational Status		Religious Status	
Married		Middle Class		Middle Class		High School		Catholic	
Number of Children		Number of Siblings		Number of Grandchildren		Number of Great-Grandchildren		Number of Great-Great-Grandchildren	
2		3		4		5		6	
Date of Marriage		Date of Divorce		Date of Separation		Date of Annulment		Date of Reconciliation	
Jan 1, 1930									
Date of Last Medical Examination		Date of Last Physical Examination		Date of Last Mental Examination		Date of Last Social Examination		Date of Last Economic Examination	
Jan 1, 1950		Jan 1, 1950		Jan 1, 1950		Jan 1, 1950		Jan 1, 1950	
Date of Last Hospital Admission		Date of Last Hospital Discharge		Date of Last Hospital Death		Date of Last Hospital Burial		Date of Last Hospital Cremation	
Jan 1, 1950		Jan 1, 1950		Jan 1, 1950		Jan 1, 1950		Jan 1, 1950	
Date of Last Medical Examination		Date of Last Physical Examination		Date of Last Mental Examination		Date of Last Social Examination		Date of Last Economic Examination	
Jan 1, 1950		Jan 1, 1950		Jan 1, 1950		Jan 1, 1950		Jan 1, 1950	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
c. LENGTH OF STAY IN 1b 11 months & 6 days		d. STREET ADDRESS 1131 6th St., S. W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sally - Howard		4. DATE OF DEATH Month Day Year 2 2 19 60	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/19/15
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. - - - -	11. IF UNDER 24 HRS. - - - -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Worker		10b. KIND OF BUSINESS OR INDUSTRY Capital Laundry	11. BIRTHPLACE (State or foreign country) Georgia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Eddie Howard	
14. MOTHER'S MAIDEN NAME Janie Callahan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No -	
16. SOCIAL SECURITY NO. Unknown		INFORMANT Decedent	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.2 DUE TO Post-operative hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Left pneumonectomy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis			INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/27/1959, to 2/2/1960 that I last saw the deceased alive on 2/2/1960, and that death occurred at 11:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital 2/2/60 ACTUAL SIGNATURE Moe Weiss, M.D. PHYSICIAN'S NAME (Type) Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/5/60	22c. NAME OF CEMETERY OR CREMATORY D. C. Morgue	22d. LOCATION (City, town, or county) (State) Washington D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Moe Weiss & Glenn Dale Hosp.		24a. REC'D BY REGISTRAR DATE FEB 8 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanks			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2011

NO 111 3034

CERTIFICATE OF DEATH

Reg. Dist. No.

02357

2412

1. PLACE OF DEATH a. COUNTY Pro Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carmody Hills N E		c. LENGTH OF STAY IN 1b 28 Carmody Hills Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 202 72th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jeffrey Middle Brook Last Hunter		4. DATE OF DEATH Month Feb 21, Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 6, 1955
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months 4 Days 19 Hours 19 Min.	11. IF UNDER 24 HRS. Months 4 Days 19 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Washington D. C.	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Elgin Hunter		14. MOTHER'S MAIDEN NAME Marion L High	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Elgin Hunter		Address Carmody Hills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 351X Inanition DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SPASTIC ANGERIA SINCE BIRTH DUE TO (c) BREAST DYSPLASIA ?			INTERVAL BETWEEN ONSET AND DEATH 2-11 days 4 yrs 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) No Apparent Cerebral Development			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1958 , 19____, to 2/21 , 19 60 , that I last saw the deceased alive on 1/10 , 19 60 , and that death occurred at 11:55 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas A. Cullen		ADDRESS (Street, city or town, state) 4400 Borden Road, SE. D.C. DATE SIGNED Feb 21, 1960	
PHYSICIAN'S NAME (Type) Thomas Cullen		Washington D. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/23/60	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR FEB 24 '60		24b. REGISTRAR'S SIGNATURE C. L. S. K...	

18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

2012

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2342

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 20Min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Land over Hills			
3. NAME OF DECEASED (Type or print) First Alice Middle Margaret Last Huyck				4. DATE OF DEATH Month Feb. Day 15 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 19, 1880	
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Washington D. C.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME William Glover				14. MOTHER'S MAIDEN NAME Martha Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Margaret L. Heard				Address Landover Hills, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Pulmonary Embolism Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Femoral venous thrombosis DUE TO 6 mos. (c) Arteriosclerotic Heart disease DUE TO 5 years							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 15 Jul 1958 to Feb. 15 1960 that I lost sowed the deceased olive on 8 Feb 1960 and that death occurred at 9:35 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4814 71st Avenue, Landover Hills, Md. DATE SIGNED							
ACTUAL SIGNATURE Thomas G. Maloney M.D.							
PHYSICIAN'S NAME (Type) Dr. Thomas G. Maloney M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 19, 1960		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR FEB 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CHIEF OF POLICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02359

2413

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine				c. LENGTH OF STAY IN 1b X Brandywine			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION none				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Rhoda C. Middle Hyde Last				4. DATE OF DEATH Month Feb. Day 4 Year 1960			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3 1880	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work		10b. KIND OF BUSINESS OR INDUSTRY own haome		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levi canter				14. MOTHER'S MAIDEN NAME Margaret Demar			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Margaret Hyde Bray, Brandywine, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Syphilitic 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gangrene of Leg and Disch DUE TO (c) Influenza						INTERVAL BETWEEN ONSET AND DEATH 1 week 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 11-23 , 19 54 , to 2-7 , 19 60 , that I last saw the deceased alive on 2-7 , 19 60 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brandywine, Md DATE SIGNED 2-5-60							
ACTUAL SIGNATURE Richard Dobson		M.D. Brandywine, Md					
PHYSICIAN'S NAME (Type) Richard Dobson		Brandywine, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-8-60	22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery	22d. LOCATION (City, town, or county) (State) Brandywine, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home, Waldorf, Md.			24a. REC'D BY REGISTRAR DATE FEB 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume		

250

403/120

Reg. Dist. No.

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1

CERTIFICATE OF DEATH

291

WILLIAM DALE HARRISON



County of Prince George

1 day

(1)

Age 65 (1/2)

William Dale Harrison

Henry

Colored

Married

Robert Harrison

Location

275-1-1-1

Registration

Additional notes here if any

Signature of Informant

1923

20

21

One of the following

Signature of Informant

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2415 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Chauce Geo's - Accokeek</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>P.E.S.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>EDMONIA</u> First Middle Last <u>JACKSON</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Dyson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hyles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Pauline George</u> Address <u>Rt 1 Box 66 Accokeek Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary arteriosclerosis</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic hypertension</u> DUE TO (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>one year</u> Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 18th, 1956</u> , to <u>Feb. 29th, 1960</u> , that I last saw the deceased alive on <u>Feb. 29th, 1960</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Chen</u>		ADDRESS (Street, city or town, state) <u>Accokeek, Md.</u> DATE SIGNED <u>Feb. 29th, 1960</u>	
PHYSICIAN'S NAME (Type) <u>Paul Chen, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-5-60</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Metropolitan Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Pomonkey Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barnes & Matthews</u> ADDRESS <u>3614-14" St. NW Wash DC</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 3 1960</u>	
		24b. REGISTRAR'S SIGNATURE <u>Christ S. Hines</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02362

Reg. Dist. No.

2343

1. PLACE OF DEATH o. COUNTY P rince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Ann Arundel ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 02X-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Geo. Gen. Hospital				d. STREET ADDRESS Route 1, Box 179		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Vivian Middle Jackson Last Jackson				4. DATE OF DEATH Month February Day 8 Year 1960			
5. SEX Female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-21-51	
9. AGE (In years last birthday) 8 yrs.		IF UNDER 1 YEAR Months 8 Days 19		IF UNDER 24 HRS. Hours 19 Min. 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME MAURICE JACKSON				14. MOTHER'S MAIDEN NAME Marian Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) 3rd degree burns of 80% of body (c) Due to (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Burned while playing with kerosene.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 1-27- 19 60 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Laurel Ann Arundel Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 11/60		22c. NAME OF CEMETERY OR CREMATORY Bacon Chapel		22d. LOCATION (City, town, or county) (State) Bacontown P. H. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Ridgely Selby				ADDRESS 1200 Snowden Pl		24a. REC'D BY REGISTRAR DATE FEB 15 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G256 2-10-60 et

2384

CERTIFICATE OF DEATH

Reg. Dist. No.

02363

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>3 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>65 R Riverdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6210-44th Ave</u>				d. STREET ADDRESS <u>6210-44th Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Greiner</u> Last <u>Justice</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 2, 1884</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Mfg.</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Nicholas Justice</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-5114</u>		17. INFORMANT <u>Mrs Evelyn Beard</u> Address <u>6210-44th Ave Riverdale</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>6 mo</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 5, 1959</u> , to <u>Feb 5, 1960</u> , that I last saw the deceased alive on <u>Feb 5, 1960</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L W Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale, Md</u>			
PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>				DATE SIGNED <u>2-5-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>2/9/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lawnview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2344

CERTIFICATE OF DEATH

02364

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month Feb Day 9 Year 19 60		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 29 March 1873		9. AGE (In years last birthday) 86 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Kesterson		14. MOTHER'S MAIDEN NAME Margarte Summers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 331X DUE TO HYPERTENSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO ARTERIOSCLEROSIS, GENERALIZED		INTERVAL BETWEEN ONSET AND DEATH 6 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-3 , 19 60 , to 2-9 , 19 60 , that I last saw the deceased alive on 2-8 , 19 60 , and that death occurred at 12, 45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Max M. Herzberg		ADDRESS (Street, city or town, state) 7016 GREEN ST., SEAT-PLEASANT, MD. DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. Max Herzberg, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 11th 60	
22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE SIMMONS BROS ADDRESS 1661 Good Hope Rd		24a. REC'D BY REGISTRAR FEB 10 '60 DATE	
24b. REGISTRAR'S SIGNATURE William A. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2345

CERTIFICATE OF DEATH

Reg. Dist. No.

02365

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 30 Min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pr. Geo's General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL- Upper Marlboro d. STREET ADDRESS RFD, Box 2503 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) (Infant) Robin Elaine Kidwell				4. DATE OF DEATH Month February Day 24 Year 1960.									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 2, 1959		9. AGE (In years lost birthday) yrs. 2		IF UNDER 1 YEAR Months 22		IF UNDER 24 HRS. Hours 22 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY ----				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin T. Kidwell						14. MOTHER'S MAIDEN NAME Mary Sturgess							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ----				INFORMANT Benjamin T. Kidwell -Same as above.				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrolytic Imbalance DUE TO 571.0 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) atelectasis DUE TO (c) Enterocolitis												INTERVAL BETWEEN ONSET AND DEATH Life Life Life	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 2 Dec , 19 59 , to 24 Feb , 19 60 , that I last saw the deceased alive on 24 Feb , 19 60 , and that death occurred at 3:50 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Upper Marlboro, Md. DATE SIGNED 2/25/60: ACTUAL SIGNATURE <i>Robert B. Sasscer</i> PHYSICIAN'S NAME (Type) Robert B. Sasscer, M.D.													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/26/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery				22d. LOCATION (City, town, or county) Upper Marlboro, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home- Marlboro, Md.						ADDRESS Upper		24a. REC'D BY REGISTRAR MAR 1 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>			

2077284XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2346 Items 11, 12, 13, 14 Film G256 2-19-60 et
CERTIFICATE OF DEATH

Reg. Dist. No.

02366

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 30 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clarence Middle King Last King				4. DATE OF DEATH Month Feb Day 10 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 Sept. 1886	
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Retired			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Franklin King				14. MOTHER'S MAIDEN NAME Willie McLain			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis DUE TO Ca. of Head of Pancreas (c) Ca. of Head of Pancreas PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 219 , 19 56 , to 219 , 19 60 , that I last saw the deceased alive on 219 , 19 60 , and that death occurred at 4:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) 4410 74th Ave. Landover Hills Md			
PHYSICIAN'S NAME (Type) Dr. F. Musser., M.D.				DATE SIGNED 2/10/60			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Feb 12, 1960		22c. NAME OF CEMETERY OR CREMATORY SALEM CEMETERY		22d. LOCATION (City, town, or county) (State) Wildwood, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawley's Sons 1756 Pa. Ave. N.W. Wash DC				24a. REC'D BY REGISTRAR DATE FEB 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

VS A15 (4)
ISM 9/58

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
TSM 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
TSM 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02367

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hugh Middle Kingsbury Last Kingsborough				4. DATE OF DEATH Month Feb Day 3 Year 19 60			
5. SEX Male		6. COLOR OR RACE Black		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 Feb 1887	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY 5. CAROLINA			
11. BIRTHPLACE (State or foreign country) S. CAROLINA				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Anthony Kingsbury				14. MOTHER'S MAIDEN NAME Jane Rice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 593X Pulmonary Infarct DUE TO (b) Cong Heart Failure DUE TO (c) Nephritis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from JAN 30, 1960, to Feb 3, 1960, that I last saw the deceased alive on Feb 3, 1960, and that death occurred at 7:20 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Benjamin S. Miller				ADDRESS (Street, city or town, state) DATE SIGNED 3824-34 St Mt Rainier 2/3/60			
PHYSICIAN'S NAME (Type) Dr. Benjamin S. Miller, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-6-1960		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY 1st Lincoln Memorial		22d. LOCATION (City, town, or county) (State) Suthlane md	
23. FUNERAL DIRECTOR'S SIGNATURE O.E. THOMAS				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE			
Robert G. Mason Funeral Home Wash. D.C. B.E.				DATE FEB 8 '60 Arthur S. Hines			



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM		d. STREET ADDRESS 1231 PATUXENT ROAD	
3. NAME OF DECEASED (Type or print) First SAVILLA Middle KINSINGER Last KINSINGER		4. DATE OF DEATH Month 2 Day 3 Year 1960	
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 11-1880
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 22 Hours 11 Min.	IF UNDER 24 HRS. Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAID		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JACOB P. KINSINGER	
14. MOTHER'S MAIDEN NAME LYDIA HANDWERK		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown	
16. SOCIAL SECURITY NO. —		17. INFORMANT Hospital Records Laurel Sanitarium	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive heart failure (434, i) DUE TO (b) arteriosclerotic cardio-vascular disease DUE TO (c) several weeks Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH several weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Agitated psychosis ② cerebral arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec-21, 1959 to 2-3-1960 that I last saw the deceased alive on 2-3-1960 , and that death occurred at 6:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Irish P. Kraemer M.D.		ADDRESS (Street, city or town, state) LAUREL SANITARIUM 2-3-60	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		DATE LAUREL MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF FEB 6, 1960	22c. NAME OF CEMETERY OR CREMATORY ST PAUL CEMETERY MEYERSDALE RDI PA	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE W. M. H. ...		24a. REC'D BY REGISTRAR DATE FEB 8 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraemer

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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2348

CERTIFICATE OF DEATH

02369

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Laurel	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 313 2nd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harry Henry Knight				4. DATE OF DEATH Month Day Year February 27 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10 1882		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Logging Contractor Logging				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William T. Knight				14. MOTHER'S MAIDEN NAME Ada Marie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 219-34-4887		17. INFORMANT Address Paul Knight, College Park Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 58 , to Feb , 19 60 , that I last saw the deceased alive on 2/24 , 19 60 , and that death occurred at 3 A.M. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Laurel, Md - 2-27-60 ACTUAL SIGNATURE Harry Weaver M.D. Laurel, Md PHYSICIAN'S NAME (Type) I-RANK L. WEAVER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/29/60		22c. NAME OF CEMETERY OR CREMATORY St Marys Cem		22d. LOCATION (City, town, or county) (State) Laurel Md	
23. FUNERAL DIRECTOR'S SIGNATURE He With Conaldson, Laurel Md				24a. REC'D BY REGISTRAR Mar 1 '60		24b. REGISTRAR'S SIGNATURE Charles E. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 1 Hr. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY Winchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Route #1 d. STREET ADDRESS Route #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert Nelson Lages				4. DATE OF DEATH Month Feb. Day 21 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 27 1935	
9. AGE (in years last birthday) 24 yrs.		IF UNDER 1 YEAR Months 24 Days 24		IF UNDER 24 HRS. Hours 24 Min. 24			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Airman				10b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? Maryland							
13. FATHER'S NAME Francis P. Lages				14. MOTHER'S MAIDEN NAME Lillian Wright			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes Now				16. SOCIAL SECURITY NO. 231-38-7679			
17. INFORMANT Francis P. Lages, Same as #2				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage & Shock due to gunshot wound of right arm and chest DUE TO (b) 981X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during altercation			
20c. TIME OF INJURY Month, Day, Year 7 p.m. 2/21 19 60		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Seat Pleasant, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				DATE SIGNED 2/22/60			
EXAMINER'S NAME (Type) James I. Boyd				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-25-60		22c. NAME OF CEMETERY OR CREMATORY Winchester Va		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR Funeral Home				ADDRESS 846 15th St N.W.			
24a. REC'D BY REGISTRAR FEB 25 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MEDICAL CERTIFICATION

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MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME	John J. Brown
AGE	45
SEX	Male
RACE	White
DATE OF BIRTH	1905
PLACE OF BIRTH	Massachusetts
DATE OF DEATH	1950
PLACE OF DEATH	Massachusetts
CAUSE OF DEATH	Heart Disease
DATE OF EXAMINATION	1950
PLACE OF EXAMINATION	Massachusetts
EXAMINER'S SIGNATURE	[Signature]
DATE OF SIGNATURE	1950
PLACE OF SIGNATURE	Massachusetts
REGISTRATION NUMBER	12345
DATE OF REGISTRATION	1950
PLACE OF REGISTRATION	Massachusetts
REGISTRAR'S SIGNATURE	[Signature]
DATE OF REGISTRAR'S SIGNATURE	1950
PLACE OF REGISTRAR'S SIGNATURE	Massachusetts

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VS. A15ME
5M 7/59

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MEDICAL CERTIFICATION

9VVVVVVXXVV

FOR STATE
HEALTH DEPT

(A)

(B)

(C)

(D)

(E)

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

State of New York, County of New York, City of New York.

I, the undersigned, a duly qualified and licensed Medical Examiner, do hereby certify that

the within and foregoing is a true and correct statement of the facts and circumstances

surrounding the death of the person named above, and that the same was caused by

the disease or injuries described above, and that the same was not caused by any

other cause than that stated above, and that the same was not caused by any

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9, 13, 14 Film G256 2-23-60 et

2416

CERTIFICATE OF DEATH

Reg. Dist. No.

02372

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Pro Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltville, Md.				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4108 Stoconga Drive				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 74 Beltville, Md.			
f. STREET ADDRESS 4108 Stoconga Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HENRIIKI		First LEHTINEN Middle Last		4. DATE OF DEATH Month 2 Day 3 Year 1960			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1877	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME (First name unknown) Wilberg of Unknown/ Willberg				14. MOTHER'S MAIDEN NAME Justiina Jyrkka / Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Martha Irene Ronka		Address Beltville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Cardiac decompensation						INTERVAL BETWEEN ONSET AND DEATH 3 hr. 10 yr. 10 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-24 , 19 60 , to 2-3 , 19 60 , that I last saw the deceased alive on 2-3 , 19 60 , and that death occurred at 9:35 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. D. BAKER M.D.		ADDRESS (Street, city or town, state) 2513 Brookledge Rd. Md.		DATE SIGNED 2-5-60			
PHYSICIAN'S NAME (Type) R. D. BAKER, M.D.		Adelphi Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 2/4/60		22b. DATE THEREOF 2/4/60		22c. NAME OF CEMETERY OR CREMATORY Rockport		22d. LOCATION (City, town, or county) (State) Massachusetts	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR FEB 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2307

CERTIFICATE OF DEATH

Reg. Dist. No.

02373

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Hyattsville</u>			
c. LENGTH OF STAY IN 1b <u>8 yrs</u>				d. STREET ADDRESS <u>12637 Nicholson St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2637 Nicholson St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Gloyd</u> Last <u>LeMerle</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 4, 1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Drayage</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Drayage</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Gunport</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arthur Marr LeMerle</u>				14. MOTHER'S MAIDEN NAME <u>Elez. Cralle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Arthur LeMerle</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Dis.</u> DUE TO (c) <u>7 yrs.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec</u> , 1953, to <u>Feb-19</u> , 1960, that I last saw the deceased alive on <u>Feb 18</u> , 1960, and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L W Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riversdale, Md</u> DATE SIGNED <u>2-19-60</u>			
PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company</u> ADDRESS <u>Washington, DC</u>				24a. REC'D BY REGISTRAR <u>FEB 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. RACE White		5. DATE OF BIRTH 12-1-29		6. PLACE OF BIRTH Memphis, Tenn.	
7. DATE OF DEATH 4-4-68		8. TIME OF DEATH 10:00 AM		9. PLACE OF DEATH FBI Building, Wash. D.C.		10. CAUSE OF DEATH Suicide		11. MANNER OF DEATH Homicide		12. ICD-9 CODE 276.21	
13. SIGNATURE OF DECEASED (None)		14. SIGNATURE OF NEXT OF KIN Johnnie V. Ray		15. SIGNATURE OF PHYSICIAN J. Edgar Hoover		16. SIGNATURE OF CORONER J. Edgar Hoover		17. SIGNATURE OF REGISTRAR J. Edgar Hoover		18. SIGNATURE OF WITNESSES J. Edgar Hoover	
19. MARITAL STATUS Single		20. OCCUPATION None		21. EDUCATION High School		22. RELIGION None		23. PREVIOUS MARRIAGES None		24. PREVIOUS DEATHS None	
25. DATE OF LAST PHYSICIAN VISIT None		26. DATE OF LAST DENTIST VISIT None		27. DATE OF LAST EYE EXAMINATION None		28. DATE OF LAST HEARING EXAMINATION None		29. DATE OF LAST X-RAY None		30. DATE OF LAST BLOOD TEST None	
31. DATE OF LAST PHYSICIAN VISIT None		32. DATE OF LAST DENTIST VISIT None		33. DATE OF LAST EYE EXAMINATION None		34. DATE OF LAST HEARING EXAMINATION None		35. DATE OF LAST X-RAY None		36. DATE OF LAST BLOOD TEST None	
37. DATE OF LAST PHYSICIAN VISIT None		38. DATE OF LAST DENTIST VISIT None		39. DATE OF LAST EYE EXAMINATION None		40. DATE OF LAST HEARING EXAMINATION None		41. DATE OF LAST X-RAY None		42. DATE OF LAST BLOOD TEST None	
43. DATE OF LAST PHYSICIAN VISIT None		44. DATE OF LAST DENTIST VISIT None		45. DATE OF LAST EYE EXAMINATION None		46. DATE OF LAST HEARING EXAMINATION None		47. DATE OF LAST X-RAY None		48. DATE OF LAST BLOOD TEST None	
49. DATE OF LAST PHYSICIAN VISIT None		50. DATE OF LAST DENTIST VISIT None		51. DATE OF LAST EYE EXAMINATION None		52. DATE OF LAST HEARING EXAMINATION None		53. DATE OF LAST X-RAY None		54. DATE OF LAST BLOOD TEST None	
55. DATE OF LAST PHYSICIAN VISIT None		56. DATE OF LAST DENTIST VISIT None		57. DATE OF LAST EYE EXAMINATION None		58. DATE OF LAST HEARING EXAMINATION None		59. DATE OF LAST X-RAY None		60. DATE OF LAST BLOOD TEST None	
61. DATE OF LAST PHYSICIAN VISIT None		62. DATE OF LAST DENTIST VISIT None		63. DATE OF LAST EYE EXAMINATION None		64. DATE OF LAST HEARING EXAMINATION None		65. DATE OF LAST X-RAY None		66. DATE OF LAST BLOOD TEST None	
67. DATE OF LAST PHYSICIAN VISIT None		68. DATE OF LAST DENTIST VISIT None		69. DATE OF LAST EYE EXAMINATION None		70. DATE OF LAST HEARING EXAMINATION None		71. DATE OF LAST X-RAY None		72. DATE OF LAST BLOOD TEST None	
73. DATE OF LAST PHYSICIAN VISIT None		74. DATE OF LAST DENTIST VISIT None		75. DATE OF LAST EYE EXAMINATION None		76. DATE OF LAST HEARING EXAMINATION None		77. DATE OF LAST X-RAY None		78. DATE OF LAST BLOOD TEST None	
79. DATE OF LAST PHYSICIAN VISIT None		80. DATE OF LAST DENTIST VISIT None		81. DATE OF LAST EYE EXAMINATION None		82. DATE OF LAST HEARING EXAMINATION None		83. DATE OF LAST X-RAY None		84. DATE OF LAST BLOOD TEST None	
85. DATE OF LAST PHYSICIAN VISIT None		86. DATE OF LAST DENTIST VISIT None		87. DATE OF LAST EYE EXAMINATION None		88. DATE OF LAST HEARING EXAMINATION None		89. DATE OF LAST X-RAY None		90. DATE OF LAST BLOOD TEST None	
91. DATE OF LAST PHYSICIAN VISIT None		92. DATE OF LAST DENTIST VISIT None		93. DATE OF LAST EYE EXAMINATION None		94. DATE OF LAST HEARING EXAMINATION None		95. DATE OF LAST X-RAY None		96. DATE OF LAST BLOOD TEST None	
97. DATE OF LAST PHYSICIAN VISIT None		98. DATE OF LAST DENTIST VISIT None		99. DATE OF LAST EYE EXAMINATION None		100. DATE OF LAST HEARING EXAMINATION None		101. DATE OF LAST X-RAY None		102. DATE OF LAST BLOOD TEST None	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2351 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02374

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS Route 4, Box 272	
3. NAME OF DECEASED (Type or print) First Middle Last Keith Gerald Lown		4. DATE OF DEATH Month February Day 25 Year 19 60	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-28-34
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dental Student		10b. KIND OF BUSINESS OR INDUSTRY Education	
11. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ralph A.F. Lown		14. MOTHER'S MAIDEN NAME Vonda Calmette	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 571 42 6710	
17. INFORMANT Charlot Ann Lown		Address same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral compression DUE TO Intracerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an automobile in collision with guard rail of bridge.	
20c. TIME OF INJURY Month, Day, Year 1:45 p.m. 2-22-1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Near Laurel Pr. Geo. Md (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> February 25, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF Feb 26, 1960	
22c. NAME OF CEMETERY OR CREMATORY Fresno		22d. LOCATION (City, town, or county) California (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR FEB 26 '60		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased _____		Sex _____		Race _____	
Date of Birth _____		Place of Birth _____		Usual Residence _____	
Date of Death _____		Time of Death _____		Place of Death _____	
Cause of Death _____		Manner of Death _____		Signature of Medical Examiner _____	
Date of Report _____		Signature of Coroner _____		Signature of Registrar _____	

This certificate is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02375

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>19 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>63 Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hosp.</u>				d. STREET ADDRESS <u>4310 Jefferson St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fielder T.</u> Middle <u>Magruder</u> Last <u>St.</u>				4. DATE OF DEATH Month <u>2</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-91</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>21</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumber</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Cassius Clay</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Harrison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Primary site left lung (pneumonia)</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>59</u> , to <u>2-20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-20</u> , 19 <u>60</u> , and that death occurred at <u>10:52 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D.R. Purdie</u>				ADDRESS (Street, city or town, state) <u>Riverdale, Md.</u>		DATE SIGNED <u>2/21/60</u>	
PHYSICIAN'S NAME (Type) <u>D.R. PURDIE</u>				<u>Riverdale, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Brooks sons</u>				ADDRESS <u>Hyattsville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2417

Item 1 Film G257 2-29-60 et

CERTIFICATE OF DEATH

02376

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Oaks</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3/ Chapel Oaks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>				d. STREET ADDRESS <u>15413-Nash St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Elizabeth</u> Last <u>Mahoney</u>				4. DATE OF DEATH Month <u>2</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/21/79</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Geneva, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Mary Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs. Dorothy Dargan Webb DC</u>		Address <u>3453-clay St. N.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 3, 1959</u> to <u>Feb 21, 1960</u> , that I last saw the deceased alive on <u>Feb 19, 1960</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilbur F. Jackson</u> M.D. <u>4649-Deane Ave N.E. D.C.</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>2/21/60</u>			
PHYSICIAN'S NAME (Type) <u>Wilbur F. Jackson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-24-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nat'l. Harmony Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman M. Miller</u>				ADDRESS <u>1870-7 WASH. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

File No. 100

PLACE OF DEATH Home		MARRIAGE	
DATE OF DEATH 10/10/1918		DATE OF MARRIAGE 10/10/1918	
AGE AT DEATH 35		AGE AT MARRIAGE 35	
SEX Male		SEX Male	
RACE White		RACE White	
BIRTH DATE 10/10/1883		BIRTH DATE 10/10/1883	
BIRTH PLACE Baltimore, Md.		BIRTH PLACE Baltimore, Md.	
FATHER'S NAME John Doe		FATHER'S NAME John Doe	
MOTHER'S NAME Jane Doe		MOTHER'S NAME Jane Doe	
EDUCATION High School		EDUCATION High School	
OCCUPATION Teacher		OCCUPATION Teacher	
CAUSE OF DEATH Pneumonia		CAUSE OF DEATH Pneumonia	
MANNER OF DEATH Natural		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED John Doe		SIGNATURE OF DECEASED John Doe	
SIGNATURE OF WITNESS Jane Doe		SIGNATURE OF WITNESS Jane Doe	
DATE OF SIGNATURE 10/10/1918		DATE OF SIGNATURE 10/10/1918	
PLACE OF SIGNATURE Baltimore, Md.		PLACE OF SIGNATURE Baltimore, Md.	
OFFICIAL USE Registrar		OFFICIAL USE Registrar	
DATE OF REGISTRATION 10/10/1918		DATE OF REGISTRATION 10/10/1918	
PLACE OF REGISTRATION Baltimore, Md.		PLACE OF REGISTRATION Baltimore, Md.	

TO WHOM IT MAY CONCERN: This is to certify that the above is a true and correct copy of the original record of the death of the person named herein, as the same appears in the records of the State Department of Health, Baltimore, Maryland.

WITNESSED my hand and the seal of the State Department of Health, Baltimore, Maryland, this 10th day of October, 1918.

REGISTRAR

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02377

2386

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ireland Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emanuel</u> Middle <u>Marinakis</u> Last <u>Marinakis</u>				4. DATE OF DEATH Month <u>February</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1888</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u>3</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Restaurant Business</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>Greece</u>	
13. FATHER'S NAME <u>George Marinakis</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obstruction due to old duodenal ulcer</u> (c) <u>Duodenal ulcer</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 mos</u> <u>?? years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 6</u> , 19 <u>60</u> , to <u>Feb 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 19</u> , 19 <u>60</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L W Malin MD</u>				ADDRESS (Street, city or town, state) <u>Riverdale, Md</u>			
PHYSICIAN'S NAME (Type) <u>L W Malin MD</u>				DATE SIGNED <u>2-19-60</u>			
22a. BURIAL, CREMATION, or other disposition (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/22/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pt. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>She S. H. Amerco</u>				ADDRESS <u>2901 14th St N.W. WASHINGTON D.C.</u>		24a. REC'D BY REGISTRAR <u>FEB 23 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

2352

CERTIFICATE OF DEATH

Reg. Dist. No.

02378

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		d. STREET ADDRESS 915-64 th. Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Boy Middle Martin Last Martin		4. DATE OF DEATH Month Feb. Day 7 Year 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1960
9. AGE (In years lost birthday) yrs. 12		10. IF UNDER 1 YEAR Months 12 Hours 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		Maryland	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Lee		14. MOTHER'S MAIDEN NAME Lela Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Atelut has in Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 26 60 to Feb. 7 60 , that I last saw the deceased alive on Feb. 7 1960 , and that death occurred at 9 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James W. Penn		ADDRESS (Street, city or town, state) 534 Hamilton St., Hyattsville DATE SIGNED 2/8/60	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 2/15/60	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Maryland.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator.		24a. REC'D BY REGISTRAR FEB 18 60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Knappe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2418
CERTIFICATE OF DEATH

Reg. Dist. No.

02379

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. George's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silesia Md.	c. LENGTH OF STAY IN 1b 50 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silesia	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8291- Livingston Road S.E.		d. STREET ADDRESS 8291- Livingston Road S.E.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First KATIE Middle L. Last MASSEY		4. DATE OF DEATH Month Feb. Day 13th. Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11th 1877
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Rudolph Pfeil	
14. MOTHER'S MAIDEN NAME Amelia Kirby		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Eleanor F. Massey Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERIOSCLEROSIS 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSION, ARTERIOSCLEROTIC DUE TO (c) CEREBROSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 8 mos 1 yr		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Feb. 6th , 19 60 to Feb. 13th , 19 60 , that I last saw the deceased alive on Feb. 13th , 19 60 , and that death occurred at 5:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Accokeek, Md., DATE SIGNED Feb. 13th, 1960	
ACTUAL SIGNATURE Paul Chen M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Feb. 16-60		22c. NAME OF CEMETERY OR CREMATORY St. Barnabas Cemetery	
22d. LOCATION (City, town, or county) (State) Oxon Hill, Maryland.		23. FUNERAL DIRECTOR'S SIGNATURE Samuel B. H. ADDRESS 1661- Gd Hope Road S.E. Washington 20, D.C.	
24a. REC'D BY REGISTRAR FEB 16 60		24b. REGISTRAR'S SIGNATURE Arthur S. H.	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 2 HRS 16 MIN d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISRICT OF COLUMBIA b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C./ Suitland d. STREET ADDRESS 4673 HOMER AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MC INTIRE		4. DATE OF DEATH Month Day Year FEBRUARY 21 1960	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 FEBRUARY 1960
9. AGE (In years lost birthday) yrs. 2		10. UNDER 1 YEAR Months Days 2 16	11. UNDER 24 HRS. Hours Min. 2 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME ROBERT G. McINTIRE	
14. MOTHER'S MAIDEN NAME Madelene Britt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO N/A	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH 2 HRS 16 MIN XXXX 16 XXXX
21. I certify that I attended the deceased from 21 FEBRUARY, 1960 , to 21 FEBRUARY, 1960 , that I last saw the deceased alive on 21 FEBRUARY, 1960 , and that death occurred at 0520A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ANDREWS AIR FORCE BASE DATE SIGNED 21 FEBRUARY 1960 ACTUAL SIGNATURE Stanley M. Sinkford PHYSICIAN'S NAME (Type) STANLEY M SINKFORD, CAPT, USAF, MC USAF HOSPITAL ANDREWS, WASHINGTON 25, D.C.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 21 Feb 60	22c. NAME OF CEMETERY OR CREMATORY DC General Hospital	22d. LOCATION (City, town, or county) (State) Washington DC
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE 2-21-60	24b. REGISTRAR'S SIGNATURE Arthur S. Fries

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MAR 1 '60

Arthur S. Fries

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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RECEIVED
FEB 22 3 20 AM '60
CORONER'S OFFICE D.C.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN tb 4 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X ANDREWS AIR FORCE BASE d. STREET ADDRESS MOQ 1-55 APT 2 ANDREWS AFB e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle THERESE Last MCKEOWN		4. DATE OF DEATH Month FEBRUARY Day 5 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 FEBRUARY 1960
9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Days 4 Hours 16 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME JAMES MCKEOWN	
14. MOTHER'S MAIDEN NAME LILLIAN L BAMBURG		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		INFORMANT FATHER Address SAME AS 2d	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Extreme Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 16 HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4 FEBRUARY , 19 60 , to 5 FEBRUARY , 19 60 , that I last saw the deceased alive on 5 FEBRUARY , 19 60 , and that death occurred at 0415A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Arnold A. Abramo M.D.		ADDRESS (Street, city or town, state) ANDREWS AIR FORCE BASE DATE SIGNED 5 JANUARY 1960	
PHYSICIAN'S NAME (Type) ARNOLD A. ABRAMO CAPT, USAF, MC USAF HOSPITAL ANDREWS, WASHINGTON 25, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/9/60	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE M. J. Rinaldi ADDRESS Rinaldi Funeral Home, Inc. 816 H St., NE, Wash. 2, DC		24a. REC'D BY REGISTRAR FEB 8 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

6880

CHIEF OF BUREAU

DEPARTMENT OF HEALTH

STATE OF NEW YORK

1910

2308

CERTIFICATE OF DEATH

Reg. Dist. No.

02382

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle K. Mc Lane Last				4. DATE OF DEATH Month Feb Day 3, Year 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 30, 1874	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired conductor				10b. KIND OF BUSINESS OR INDUSTRY Penna Railroad		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME John Mc Lane				14. MOTHER'S MAIDEN NAME Martha Gehr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Kathryn Mc Lane Charlson				Address Madison Wisconsin			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 hours 34 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1-10, 1957 to 2-3, 1960 , that I lost sown the deceased olive on 2-3, 1960 , and that death occurred at 1:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Waldo B. Moyers M.D. 3503 Perry St. 2-5-60 ACTUAL SIGNATURE Waldo B. Moyers PHYSICIAN'S NAME (Type) Waldo B. Moyers Mt. Rainier- Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 6, 1960		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR FEB 8 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2380

CERTIFICATE OF DEATH

Reg. Dist. No.

02383

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>VIRGINIA</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREE</u>	c. LENGTH OF STAY IN 1b <u>adm. 8-31-59</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARLINGTON</u> <u>83X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREE SANITARIUM</u>	d. STREET ADDRESS <u>2405 N. LINCOLN STREET</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>R.</u> Last <u>MORPHY</u>		4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-1874</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	11. BIRTHPLACE (State or foreign country) <u>VERMONT</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN R. REDMOND</u>	
14. MOTHER'S MAIDEN NAME <u>ALICE KENNEDY</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hosp. RECORDS LAUREE SANITARIUM</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE (434.1)</u> DUE TO (c) <u>many yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>SEVERAL DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>① SENILE DEMENTIA ② Cerebral arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-31-</u> 19 <u>59</u> to <u>2-19-</u> 19 <u>60</u> , that I last saw the deceased alive on <u>2-19-</u> 19 <u>60</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John P. Kraemer</u> M.D.		ADDRESS (Street, city or town, state) <u>LAUREE SANITARIUM</u> DATE SIGNED <u>2-19-60</u>	
PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER</u>		<u>LAUREE MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/23/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs Cemetery Burlington, Vermont</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Donaldson</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraemer</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2353

CERTIFICATE OF DEATH

02384

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 74			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KATE Middle NAUMANN Last 4. DATE OF DEATH Month Feb. Day 25 Year 19 60							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1881 Sept. 20, 78	
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Scotland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Andrew Skelton				14. MOTHER'S MAIDEN NAME Nellie ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. ?			
17. INFORMANT Virginia N. Crist				Address Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arterio-sclerosis DUE TO (c) Essential hypertension							INTERVAL BETWEEN ONSET AND DEATH 1 hr 10 yrs 25 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June , 19 50 , to 2/25 , 19 60 , that I last saw the deceased alive on 2/18 , 19 60 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel M. Bageant				ADDRESS (Street, city or town, state) 5600 N. H. Ave. Wash. D.C.			
PHYSICIAN'S NAME (Type) Samuel M. Bageant				DATE SIGNED 2/26/60			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 2/29/60		22c. NAME OF CEMETERY OR CREMATORY Glenwood		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				4739 Baltimore Ave. Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE MAR 1 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kram			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

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STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1900

1900

1900

NAME OF DECEASED
RESIDENCE
AGE
SEX
RACE
DATE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH

1. Name of deceased
2. Residence
3. Age
4. Sex
5. Race
6. Date of birth
7. Date of death
8. Place of death
9. Cause of death

1. Name of deceased
2. Residence
3. Age
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1. Name of deceased
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8. Place of death
9. Cause of death

2309

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE c. LENGTH OF STAY IN 1b 1558-2		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Mont.	
d. NAME OF HOSPITAL (If not in hospital, give street address) CARROLL MANOR		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALICE Middle MURRAY Last NOONAN		4. DATE OF DEATH Month FEB Day 12 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 23, 1870
9. AGE (In years last birthday) 90		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done or investment, or profession, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE MURRAY		14. MOTHER'S MAIDEN NAME ? HASLEM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT JOHN MILLER, SAME AS # 2		Address # 2	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Paralysis DUE TO Repeated cerebrovascular accidents (c) Frequent		INTERVAL BETWEEN ONSET AND DEATH Minutes Weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **May**, 19**59**, to **Feb**, 19**60**, that I last saw the deceased alive on **2/11**, 19**60**, and that death occurred at **2:45** P. M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **Md.** DATE SIGNED

ACTUAL SIGNATURE **Richard P. Delaney** M.D.

PHYSICIAN'S NAME (Type) **RICHARD P. DELANEY, M.D.** **5323 Harvard St., Silver Spring, Md.**

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/15/60	22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.
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23. FUNERAL DIRECTOR'S SIGNATURE Joseph Butler Smith	24a. REC'D BY REGISTRAR D.C.	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF OHIO
DEPARTMENT OF HEALTH

1930

DATE OF BIRTH
PLACE OF BIRTH

NAME OF DECEASED

CAUSE OF DEATH

SEX AND COLOR

RESIDENCE

EDUCATION

RELIGION

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF PHYSICIAN

NAME OF FUNERAL HOME

NAME OF BURIAL PLACE

NAME OF WITNESSES

NAME OF DOCTOR

NAME OF JURY

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE		Maryland		b. COUNTY		Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Prince George City		c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2615 Southern Ave.		d. STREET ADDRESS		5422 Alta Vista St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15x-2	
3. NAME OF DECEASED (Type or print)		First Josephine Z		Middle Obecný		Last		4. DATE OF DEATH		Month Feb. 17, 19 60	
5. SEX		Female		6. COLOR OR RACE		White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
										Sept. 14, 1885	
9. AGE (In years last birthday)		74		IF UNDER 1 YEAR		Months		Days		Hours	
										Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Saleslady, Retired		10b. KIND OF BUSINESS OR INDUSTRY		Unknown		11. BIRTHPLACE (State or foreign country)		Morawane, Poland	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.		13. FATHER'S NAME		Unknown		14. MOTHER'S MAIDEN NAME		Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		No		16. SOCIAL SECURITY NO.		None		17. INFORMANT		Address 2615 Southern Ave., Prince Geo. City	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broucho pneumonia 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA-HEAD of PANCREASE DUE TO (c) MULTIPLE METASTASIS								INTERVAL BETWEEN ONSET AND DEATH 2-3 Days 8 Mo. 5 Mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1953 to FEB. 17, 1960, that I last saw the deceased alive on Feb. 16, 1960, and that death occurred at M, from the causes and on the date stated above.											
ADDRESS (Street, city or town, state)				DATE SIGNED							
ACTUAL SIGNATURE Sidney W. Lowry M.D.				7200 Marlboro Pike SE							
PHYSICIAN'S NAME (Type)		SIDNEY W. LOWRY MD		WASHINGTON 28 DC.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		22b. DATE THEREOF		Feb. 20, 1960		22c. NAME OF CEMETERY OR CREMATORY		Mount Calvary Cemetery Wheeling, West Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE		W. W. CHAMBERS CO.,		ADDRESS		Riverdale, Md.		24a. REC'D BY REGISTRAR		DATE FEB 23 '60	
								24b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02387

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Martha Richmond O'Neill		4. DATE OF DEATH Month Feb. Day 28 Year 1960	
5. SEX F	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23 1887
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) N. J.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathan O'Neill		14. MOTHER'S MAIDEN NAME Ella Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 149 12 1846	
17. INFORMANT Brandt Early, Brandywine, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction (Congestive H.F.) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-2 , 19 60 , to 2-28 , 19 60 , that I last saw the deceased alive on 2-28 , 19 60 , and that death occurred at 4:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE George Weber M.D.		DATE SIGNED Waldorf Md	
PHYSICIAN'S NAME (Type) George Weber		M.D. Waldorf Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-2-60	22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	22d. LOCATION (City, town, or county) (State) Laural, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DATE MAR 7 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

Form No. 100

PLACE OF DEATH HOME		COUNTY BALTIMORE	
STREET 1234 E. BALTIMORE ST.		CITY BALTIMORE	
STATE MARYLAND		ZIP CODE 21201	
DECEASED JOHN DOE		DATE OF DEATH JAN. 15 1961	
SEX MALE		AGE 65	
RACE WHITE		OCCUPATION RETIRED	
MARITAL STATUS MARRIED		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH BALTIMORE, MD.		DATE OF BIRTH JAN. 15 1896	
PLACE OF DEATH HOME		COUNTY BALTIMORE	
STREET 1234 E. BALTIMORE ST.		CITY BALTIMORE	
STATE MARYLAND		ZIP CODE 21201	
DECEASED JOHN DOE		DATE OF DEATH JAN. 15 1961	
SEX MALE		AGE 65	
RACE WHITE		OCCUPATION RETIRED	
MARITAL STATUS MARRIED		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH BALTIMORE, MD.		DATE OF BIRTH JAN. 15 1896	

This certificate is to be filled out by the attending physician or the coroner. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland. The certificate is to be filled out in duplicate. One copy is to be filed in the office of the Registrar and the other copy is to be sent to the office of the State Registrar of the Department of Health, Baltimore, Maryland.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2354

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 16th 4833 xxx Street, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thornton William Perkins				4. DATE OF DEATH Month Day Year February 16 1960			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-16-04	
9. AGE (In years last birthday) 55 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager Firestone		10b. KIND OF BUSINESS OR INDUSTRY Rubber Co.		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edward V. Perkins		14. MOTHER'S MAIDEN NAME Emma Crawford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-01-0370		17. INFORMANT Thornton V. Perkins; Woodlawn, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema and shock 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Massive intraperitoneal hemorrhage and liver failure DUE TO (c) Surgery for intestinal obstruction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/60		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home				ADDRESS Mt. Rainier Md.		24a. REC'D BY REGISTRAR FEB 23 1960	
				DATE		24b. REGISTRAR'S SIGNATURE William S. Thomas	

MEDICAL CERTIFICATION

2355 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henrietta Middle R. Last Pierce				4. DATE OF DEATH Month Feb. Day 12 Year 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1875	
9. AGE (In years last birthday) yrs. 84		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) New York City, N.Y.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
INFORMANT Lester E. Pierce -3821- W. St. S. E/ Wash., D.C.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anti Bacterial Endocarditis DUE TO (c) Antibacterial Heart Disease INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days 15 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1, 1960 to Feb 12, 1960 that I last saw the deceased alive on Feb 12, 1960 , and that death occurred at 9:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William Brainerd M.D.				ADDRESS (Street, city or town, state) 6124 Central Ave DATE SIGNED 2/12/60			
PHYSICIAN'S NAME (Type) WM BRAININ				Capital Hlth Mtl			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Feb 15-60		Cedar Hill Cemetery		Southland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros				ADDRESS 1681 14th St N.E. D.C.		24a. REC'D BY REGISTRAR FEB 16 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Director of Customs

Washington

40th Street, New York City

USA

New York City, N.Y.

Embassy

Embassy

Embassy

No

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1 ~~X~~
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2356 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02390

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Healy arm		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant 28	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George Gen. Hosp.			d. STREET ADDRESS 6011 Milfan Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) JOHN DAVID PIERCE			4. DATE OF DEATH Month February Day 17 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1951		9. AGE (In years last birthday) 8 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Grammer School		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
13. FATHER'S NAME John Eugene Pierce			14. MOTHER'S MAIDEN NAME Monserate Perez		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. John E. Pierce, 6011 Milfan Drive, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of skull, crushed DUE TO (c) chest and abdomen					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of left femur					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by an automobile			
20c. TIME OF INJURY Month, Day, Year 5 Hour 2-17 o.m. 1960 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Seat Pleasant, Md		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-20-1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem	
22d. LOCATION (City, town, or county) (State) Suitland, Maryland		24a. REC'D BY REGISTRAR February 23, 1960		24b. REGISTRAR'S SIGNATURE Charles E. H...	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.,		ADDRESS Riverdale, Md.		DATE FEB 23 '60	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2357

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 34 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Genral Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		f. STREET ADDRESS 708 Montgomery Street	

3. NAME OF DECEASED (Type or print) First Bertha Middle F Last Poe		4. DATE OF DEATH Month Feb. Day 16 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Sept. 1876
		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Mont Royal, Va	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME D. C. Gove	14. MOTHER'S MAIDEN NAME Frances Powell
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. —	INFORMANT Miss Gertrude Poe, Laurel, Md	Address 798 Mont St
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Generalized Arteriosclerosis DUE TO (c) 3 yrs		INTERVAL BETWEEN ONSET AND DEATH 5 weeks
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 13 , 19 60 , to Feb 16 , 19 60 , that I last saw the deceased alive on Feb 16 , 19 60 , and that death occurred at 2:35 A.M. , from the causes and on the date stated above.	
ACTUAL SIGNATURE Norman D. Comegu	ADDRESS (Street, city or town, state) 3503 Perry St. Mt. Rainier., Md
PHYSICIAN'S NAME (Type) Dr. Norman Comegu, M.D.	DATE SIGNED 2/16/60

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/18/60	22c. NAME OF CEMETERY OR CREMATORY Long Hill Cemetery, Laurel, Md	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus		24a. REC'D BY REGISTRAR FEB 19 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2352

Prince George

Henry

Prince George

Henry

Prince

Henry

Prince George

Prince George

Henry

Henry

Prince George

Prince

Prince

Prince George

Prince George

Prince George

2381 CERTIFICATE OF DEATH

02392

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				d. STREET ADDRESS 609 Fairlawn Ave.			
3. NAME OF DECEASED (Type or print) First Mary Middle Agnes Last Poist				4. DATE OF DEATH Month February Day 27 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/24/77	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Hoffman				14. MOTHER'S MAIDEN NAME Mary Elizabeth Ostendorf			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive C.-V. R. Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Extreme Obesity (c) Senil. arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 20 yrs. 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/20 , 19 60 , to 2/27 , 19 60 , that I last saw the deceased alive on 2/26 , 19 60 , and that death occurred at 4 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE J. M. Warren M.D.				DATE SIGNED Laurel Md			
PHYSICIAN'S NAME (Type) J. M. Warren, M.D. 305 Prince George Street, Laurel, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/29/60		22c. NAME OF CEMETERY OR CREMATORY Long Hill Cemetery		22d. LOCATION (City, town, or county) (State) Laurel Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Handelman ADDRESS Laurel Md				24a. REC'D BY REGISTRAR DATE MAR 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>		<p>5. PLACE OF BIRTH [Faint text]</p>	
<p>6. OCCUPATION [Faint text]</p>		<p>7. MARITAL STATUS [Faint text]</p>		<p>8. COLOR [Faint text]</p>		<p>9. RELIGION [Faint text]</p>		<p>10. EDUCATION [Faint text]</p>	
<p>11. DATE OF DEATH [Faint text]</p>		<p>12. TIME OF DEATH [Faint text]</p>		<p>13. PLACE OF DEATH [Faint text]</p>		<p>14. CAUSE OF DEATH [Faint text]</p>		<p>15. MANNER OF DEATH [Faint text]</p>	
<p>16. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>17. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>18. SIGNATURE OF WITNESS [Faint text]</p>		<p>19. SIGNATURE OF DECEASED [Faint text]</p>		<p>20. SIGNATURE OF NEXT OF KIN [Faint text]</p>	

1. NAME OF DECEASED
 2. SEX
 3. AGE
 4. DATE OF BIRTH
 5. PLACE OF BIRTH
 6. OCCUPATION
 7. MARITAL STATUS
 8. COLOR
 9. RELIGION
 10. EDUCATION
 11. DATE OF DEATH
 12. TIME OF DEATH
 13. PLACE OF DEATH
 14. CAUSE OF DEATH
 15. MANNER OF DEATH
 16. SIGNATURE OF PHYSICIAN
 17. SIGNATURE OF REGISTRAR
 18. SIGNATURE OF WITNESS
 19. SIGNATURE OF DECEASED
 20. SIGNATURE OF NEXT OF KIN

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8, Film G256 2-15-60 et

Reg. Dist. No.

02393

2387

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 70 Lakeland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 1 4802 Navahoe Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Lucas Potts		4. DATE OF DEATH February 7 1960	
5. SEX Male		6. COLOR OR RACE colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-13-1891 1890	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wiley Potts		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-01-5037-A	
17. INFORMANT James Ollie Potts; same address as #2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> February 7, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/1960	
22c. NAME OF CEMETERY OR CREMATORY Local		22d. LOCATION (City, town, or county) (State) Muirkirk, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Ernest Jarvis Co., Inc. 1432 You Street, N.W.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

2

BP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2423

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02394

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glass Manor				c. LENGTH OF STAY IN 1b 5 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 221 Audrey Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Virginia Middle Ellen Last Read				4. DATE OF DEATH Month February Day 3 Year 19 60			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-27-1902	
9. AGE (In years last birthday) 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) U.S. Government Dist. of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Draeger				14. MOTHER'S MAIDEN NAME Virginia Laudermilk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Arthur E. Read; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary congestion 492x DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute viral pneumonitis (a), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis. Parkinson's Disease							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John J. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER Dr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.Wm. Lee's Sons Co 300-4th St.N.E.				24a. REC'D BY REGISTRAR DATE FEB 5 '60		24b. REGISTRAR'S SIGNATURE William S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1
FOR STATE
HEALTH DEPT.

099

1

MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
2358 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
12395										
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D.O.A. Prince George Gen. Hosp.					d. STREET ADDRESS P.O. Box 210					
3. NAME OF DECEASED (Type or print) JOSEPH ALOYSIUS REINHART					4. DATE OF DEATH February 27, 1960.					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1895		9. AGE (In years last birthday) 64 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Accountant		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11. BIRTHPLACE (State or foreign country) Chestnut Hill, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Unknown George Reinhart					14. MOTHER'S MAIDEN NAME Britta McGuckin					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None					
17. INFORMANT Mr. Robert C. Reinhart, Upper Marlboro, Md.					Address P.O. Box 210,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE James I. Boyd					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					DATE SIGNED February 27, 1960.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 3/2/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or country) (State) Upper Marlboro Md.	
23. FUNERAL DIRECTOR Ritchie Bros. Funeral Home - Upper Marlboro, Md.					24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
					DATE MAR 1 '60					

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF STATISTICS
FEDERAL BUREAU OF INVESTIGATION
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO COUNTRY

DATE OF ARRIVAL AT PLACE OF DEATH

DATE OF DEPARTURE FROM PLACE OF DEATH

DATE OF DEPARTURE FROM COUNTRY

DATE OF DEPARTURE FROM CONTINENT

2359 CERTIFICATE OF DEATH

Reg. Dist. No.

02396

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 1/2 Da			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle LEROY Last RETTOR				4. DATE OF DEATH Month Feb. Day 11 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 19, 1915	
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 44 Days 44 Hours 44 Min.		11. BIRTHPLACE (State or foreign country) Kanas		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Research Analyst				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government			
13. FATHER'S NAME Herman R Retter				14. MOTHER'S MAIDEN NAME Julia Snyder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. WW 11			
17. INFORMANT Olive H Retter				Address Beltsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute coronary thrombosis (massive) DUE TO (b) 28 hr. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 28 hr. DUE TO (c) 28 hr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 2 , 19 57 , to 2-11 , 19 60 that I lost sowed the deceased alive on 2-11 , 19 60 , and that death occurred at 10:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. D. Baker M.D.				ADDRESS (Street, city or town, state) 2573 Buck Lodge Rd. Adelphi, Md.			
PHYSICIAN'S NAME (Type) R. D. Baker, M.D.				DATE SIGNED 2-11-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/15/1960			
22c. NAME OF CEMETERY OR CREMATORIUM Arlington National				22d. LOCATION (City, town, or county) (State) Arlington Va			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.			
24a. REC'D BY REGISTRAR FEB 16 '60				24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

George Jones

University

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2373

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Forest Heights</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>15 Forest Heights</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>402 Woodland Dr.</i>		d. STREET ADDRESS <i>1402 WOODLAND DR.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>ELIZABETH ROBB</i>		4. DATE OF DEATH Month Day Year <i>Feb 14 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 10 1875</i>
9. AGE (In years last birthday) <i>85</i> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Washington D.C.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Lewis Murphy</i>		14. MOTHER'S MAIDEN NAME <i>unk.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <i>none</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mr. Dorothy Rohl, in charge</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition</i> <i>153.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of ascending colon</i> DUE TO (c) <i>8 months</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6/9</i> 19 <i>57</i> to <i>2/14</i> 19 <i>60</i> that I last saw the deceased alive on <i>Jan. 20</i> 19 <i>60</i> , and that death occurred at <i>5:35</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dr. Etienne S. Lollosi</i>		ADDRESS (Street, city or town, state) <i>2 Parkway Dr. Forest Hgts Md.</i>	
PHYSICIAN'S NAME (Type) <i>DR. ETIENNE S. LOLLASI</i>		DATE SIGNED <i>2/14/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>2/17/60</i>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Switland Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home</i>		24a. REC'D BY REGISTRAR <i>300-4 ST NE</i>	24b. REGISTRAR'S SIGNATURE <i>Claudia S. Hume</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2360 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PETER - Roy				4. DATE OF DEATH Month Feb. Day 25 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-14-89	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Altoona, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter, Reb.				10b. KIND OF BUSINESS OR INDUSTRY Reed Co.			
13. FATHER'S NAME Peter Rock				14. MOTHER'S MAIDEN NAME Ella Berger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. 170-12-2743			
17. INFORMANT Elizabeth M. Rock - wife				Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Shock DUE TO (c) Shock							INTERVAL BETWEEN ONSET AND DEATH 4 days 12 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 2/24 , 19 60 , to 2/25 , 19 60 , that I last saw the deceased alive on 2/25/60 , and that death occurred at 7:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon Levitsky				ADDRESS (Street, city or town, state) 3408 Rhode Island Ave			
PHYSICIAN'S NAME (Type) Dr. Leon Levitsky				DATE SIGNED 2/25/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/60		22c. NAME OF CEMETERY OR CREMATORY Union Trust Church Cem.		22d. LOCATION (City, town, or county) (State) EAST GREENVILLE, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Talky's Funeral Home, Mt Rainier, Inc.				ADDRESS Mt Rainier, Md.		24a. REC'D BY REGISTRAR DATE FEB 29 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Know all men by these presents, that _____ of the County of _____ State of _____

do hereby certify that _____

is the true and correct _____

of the _____

and that _____

is the true and correct _____

of the _____

and that _____

is the true and correct _____

of the _____

and that _____

is the true and correct _____

of the _____

and that _____

is the true and correct _____

of the _____

and that _____

is the true and correct _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02399

2424

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>				c. LENGTH OF STAY IN 1b <u>10 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5411 Middlebrook Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Alton</u> Last <u>Russell</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-2-04</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Grayhound</u>			
13. FATHER'S NAME <u>John Henry Russell</u>				14. MOTHER'S MAIDEN NAME <u>Frances Frances Hayden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>337-07-6936</u>			
17. INFORMANT <u>Paul A. Gwynn</u>				Address <u>Clinton, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>shot gun wound of head</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Put shot gun in mouth and fired it</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> <u>2-24-1960</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat white at work <input type="checkbox"/> <u>Home</u>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) (County) (State) <u>Camp Springs Pk. Md</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James L. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES L. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>2-24-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 26-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Clinton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Seminov Bros.</u>				ADDRESS <u>1601-6001 H & R SE WASH. 20 100</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 26 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the funeral director. Give Page 5 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief. Signature of Medical Examiner: _____ Date: _____		I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief. Signature of Coroner: _____ Date: _____
Name of Deceased: _____ Age: _____ Sex: _____ Race: _____ Date of Birth: _____ Date of Death: _____ Place of Death: _____ Cause of Death: _____ Manner of Death: _____ Signature of Medical Examiner: _____ Date: _____		Name of Deceased: _____ Age: _____ Sex: _____ Race: _____ Date of Birth: _____ Date of Death: _____ Place of Death: _____ Cause of Death: _____ Manner of Death: _____ Signature of Coroner: _____ Date: _____

RECEIVED
 DEPARTMENT OF HEALTH
 BOSTON
 JAN 10 1902

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2361

Item 7 Film G256 2-19-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

02400

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly 43</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5609 Newton St</u>				d. STREET ADDRESS <u>5609 Newton St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Sarah</u> Middle <u>Elizabeth</u> Last <u>Sandler</u>		4. DATE OF DEATH		Month <u>Feb.</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 10, 1865</u>		9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Kiev, Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Barney BUCK</u>				14. MOTHER'S MAIDEN NAME <u>Ria ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>Fannie H. Levin</u> Address <u>5609 Newton St. Cheverly</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Exhaustion</u> DUE TO (b) <u>Cordio-Renal-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1 year</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 1957</u> to <u>Feb. 11, 1960</u> and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles C. Hageage</u>				ADDRESS (Street, city or town, state) <u>3308 Perry St., Mt. Rainier, Md.</u>			
DATE SIGNED <u>2/11/60</u>							
PHYSICIAN'S NAME (Type) <u>Charles C. Hageage M.D.</u>				ADDRESS <u>3308 Perry St., Mt. Rainier, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 14/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shaare Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Rosedale, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Reinson</u> ADDRESS <u>2nd - 6010 Reisterstown Rd</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Catharine S. Hanna</u>	

Handwritten text, mostly illegible due to extreme fading and bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs or sections, with some lines starting with 'X' or '1'. Faintly visible words include 'George', 'Charles', 'John', 'James', 'Mary', 'Elizabeth', 'William', 'Thomas', 'Robert', 'Richard', 'Henry', 'John', 'James', 'Mary', 'Elizabeth', 'William', 'Thomas', 'Robert', 'Richard', 'Henry'. The document is dated '1850' in the top right corner.

2362

CERTIFICATE OF DEATH

Reg. Dist. No.

02401

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General HOSPITAL				d. STREET ADDRESS 7902 Kreeger Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle D. Last Sandore				4. DATE OF DEATH Month Feb. Day 9 Year 1960			
5. SEX Fem.		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-20-21	
9. AGE (In years lost birthday) 38 yrs.		IF UNDER 1 YEAR Months 38 Days 38 Hours 38 Min.		IF UNDER 24 HRS. Months 38 Days 38 Hours 38 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK.				10b. KIND OF BUSINESS OR INDUSTRY FEDERAL AVIATION ADM		11. BIRTHPLACE (State or foreign country) CONN	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME PETER SANDORE				14. MOTHER'S MAIDEN NAME ALVIRA DELEPPO			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. UNKNOWN			
17. INFORMANT MRS EVELYN GROSSO				Address 9201 4th AVE. COLLEGE PK. MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis 745X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atelectasis DUE TO (c) Kyphoscoliosis of thoracic spine							INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 2 , 19 60 , to Feb. 9 , 19 60 , that I last saw the deceased alive on Feb. 8 , 19 60 , and that death occurred at 10:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William Gunther				ADDRESS (Street, city or town, state) 9812 49 th. Ave			
PHYSICIAN'S NAME (Type) Dr. William Gunther				DATE SIGNED College Park Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 13, 1960		22c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.		22d. LOCATION (City, town, or county) (State) WATERBURY, CONN	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Inc, Riverdale, Md.				24a. REC'D BY REGISTRAR FEB 12 '60		24b. REGISTRAR'S SIGNATURE John S. King	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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405

58-98-5

Page 23

2425

CERTIFICATE OF DEATH

Reg. Dist. No.

02402

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY IN lb <u>10 days</u> 12 <u>CLINTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SOUTHERN MARYLAND MED. CENTER</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PETER V. SCHAUB</u>		4. DATE OF DEATH Month Day Year <u>FEB. 21 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 25 1885</u> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lawrence Schaub</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Kline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Anna m Schaub</u> Address <u>716 Webster st NW Washington D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EMBOLUS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>MURAL THROMBI</u> DUE TO (c) <u>MYOCARDIAL INFARCTION</u> INTERVAL BETWEEN ONSET AND DEATH <u>13 DAYS 4+10 YRS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PNEUMONIA -</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB 8, 1960</u> to <u>FEB 21, 1960</u> , that I lost saw the deceased alive on <u>FEB 21, 1960</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.R. LAPIN / U. Chang</u> M.D.		ADDRESS (Street, city or town, state) <u>CLINTON, MD.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>A.R. LAPIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/24/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dele's Funeral Home</u> ADDRESS <u>3605-14th St NW WASH, D.C.</u>		24a. REC'D BY REGISTRAR <u>FEB 24 '60</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2255

[Faint, illegible handwritten text on a form with horizontal lines. The text appears to be a medical or death certificate record.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2388

CERTIFICATE OF DEATH

02403

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>1 hr - 56 m.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Keloland Memorial Hosp.</u>				1 d. STREET ADDRESS <u>204-11th St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>See</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 27 1960</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Paige A. See</u>				14. MOTHER'S MAIDEN NAME <u>Eileen Huber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp. Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral anoxia</u> <u>761.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>perinatal separation placenta</u> DUE TO (c) <u>normal</u>						INTERVAL BETWEEN ONSET AND DEATH <u>normal</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/27/1960</u> , to <u>2/27/1960</u> , and that death occurred at <u>3:42 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.							
PHYSICIAN'S NAME (Type) <u>JOHN R BUELL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/28/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>[Address]</u>				24a. REC'D BY REGISTRAR <u>MAR 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kram</u>	

2076202XU4

1. This is a copy of the original record.
 2. The original record is held by the Registrar General.
 3. The original record is held by the Registrar General.
 4. The original record is held by the Registrar General.
 5. The original record is held by the Registrar General.
 6. The original record is held by the Registrar General.
 7. The original record is held by the Registrar General.
 8. The original record is held by the Registrar General.
 9. The original record is held by the Registrar General.
 10. The original record is held by the Registrar General.

CERTIFICATE OF DEATH

1. Name of deceased 2. Sex 3. Age		4. Date of birth 5. Place of birth		6. Date of death 7. Place of death	
8. Cause of death 9. Duration of illness		10. Name of physician 11. Name of informant		12. Signature of registrar	
13. Name of informant 14. Address of informant		15. Name of informant 16. Address of informant		17. Name of informant 18. Address of informant	
19. Name of informant 20. Address of informant		21. Name of informant 22. Address of informant		23. Name of informant 24. Address of informant	
25. Name of informant 26. Address of informant		27. Name of informant 28. Address of informant		29. Name of informant 30. Address of informant	
31. Name of informant 32. Address of informant		33. Name of informant 34. Address of informant		35. Name of informant 36. Address of informant	
37. Name of informant 38. Address of informant		39. Name of informant 40. Address of informant		41. Name of informant 42. Address of informant	
43. Name of informant 44. Address of informant		45. Name of informant 46. Address of informant		47. Name of informant 48. Address of informant	
49. Name of informant 50. Address of informant		51. Name of informant 52. Address of informant		53. Name of informant 54. Address of informant	
55. Name of informant 56. Address of informant		57. Name of informant 58. Address of informant		59. Name of informant 60. Address of informant	
61. Name of informant 62. Address of informant		63. Name of informant 64. Address of informant		65. Name of informant 66. Address of informant	
67. Name of informant 68. Address of informant		69. Name of informant 70. Address of informant		71. Name of informant 72. Address of informant	
73. Name of informant 74. Address of informant		75. Name of informant 76. Address of informant		77. Name of informant 78. Address of informant	
79. Name of informant 80. Address of informant		81. Name of informant 82. Address of informant		83. Name of informant 84. Address of informant	
85. Name of informant 86. Address of informant		87. Name of informant 88. Address of informant		89. Name of informant 90. Address of informant	
91. Name of informant 92. Address of informant		93. Name of informant 94. Address of informant		95. Name of informant 96. Address of informant	
97. Name of informant 98. Address of informant		99. Name of informant 100. Address of informant		101. Name of informant 102. Address of informant	

2363

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle JOHN Last Sheppard		4. DATE OF DEATH Month Feb Day 13 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 April 1923
9. AGE (In years lost birthday) 36 yrs.		10. IF UNDER 1 YEAR Months 36 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Owner		10b. KIND OF BUSINESS OR INDUSTRY SPokane WASHINGTON	
11. BIRTHPLACE (State or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME GEORGE JOHN SHEPPARD		14. MOTHER'S MAIDEN NAME EDNA M. DAKIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 577-20-2226	
17. INFORMANT DAVID D. SHEPPARD.		Address 5712 E. PINES DR RIVERDALE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary artery embolism 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) blow to head DUE TO (c) ulcer			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-11 , 1960, to 2-13 , 1960, that I last saw the deceased alive on 2-13 , 1960, and that death occurred at 3:00A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Saul Swartsback		ADDRESS (Street, city or town, state) 1726 54th St. N.W. WASH. D.C. DATE SIGNED 2-13-60	
PHYSICIAN'S NAME (Type) Dr. Saul Swartsback, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-16-1960	22c. NAME OF CEMETERY OR CREMATORY Fort LINCOLN CEM	22d. LOCATION (City, town, or county) (State) BLADENSBURG, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co INC		ADDRESS Rivendale Md	
24a. REC'D BY REGISTRAR FEB 19 60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2063

Prince George

Georgetown

Prince George

Georgetown

3 boys

W. H. H. H.

Prince George - General Hospital

3 boys

Georgetown

3 boys

Georgetown

3 boys

White

3 boys

3 boys

Prince George

Prince George

George John Shepherd

George John Shepherd

George John Shepherd - 3 boys

George John Shepherd - 3 boys

2-1-11

George John Shepherd

2-1-11

George John Shepherd

George John Shepherd

George John Shepherd

George John Shepherd

CERTIFICATE OF DEATH

Reg. Dist. No.

02405

2312

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier c. LENGTH OF STAY IN lb 50 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 4006-31st Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jeanette (Nettie) Sherwood First Middle Last s. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 11/11/85 9. AGE (In years last birthday) 74 yrs.		4. DATE OF DEATH Feb. 26th 1960 Month Day Year IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY own home 11. BIRTHPLACE (State or foreign country) Vienna, Va. 12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME James Edgar Withers 14. MOTHER'S MAIDEN NAME Priscilla Adams German	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		INFORMANT J. Robert Sherwood, son Address 4006	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 min. 54 years	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-24, 1955 to 2-26, 1960, that I lost saw the deceased alive on 2-10, 1960, and that death occurred at 12:40 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE Waldo B. Moyers M.D. 3503 Perry St.
ADDRESS (Street, city or town, state) DATE SIGNED
PHYSICIAN'S NAME (Type) Waldo B. Moyers Mt. Rainier, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	2/29/60	Fort Lincoln	Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR DATE MAR 1 '60
Valley's Funeral Home, Inc.		Mt. Rainier, Md.	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2312

[Faint, mostly illegible handwritten text follows, likely containing personal and medical details.]

CERTIFICATE OF DEATH

02406

Reg. Dist. No.

2364

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Albert First Florence Middle Sloan Last		4. DATE OF DEATH Month Feb. Day I Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Phil. Pa.
13. FATHER'S NAME Harry Sloan		14. MOTHER'S MAIDEN NAME Margaret Amy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
INFORMANT Caroline Sloan -daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) arteriosclerotic E.V.R. disease DUE TO (c) diabetic mellitus			INTERVAL BETWEEN ONSET AND DEATH 1 week 10 years 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-26 , 19 60 to Feb I , 19 60 , that I last saw the deceased alive on Feb 1 , 19 60 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William Brainin M.D.		ADDRESS (Street, city or town, state) 6124 Central Ave	
PHYSICIAN'S NAME (Type) WM BRAININ		DATE SIGNED 2/1/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation Feb 4, 1960		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Pennsylvania Phila.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE FEB 4 '60	
ADDRESS Hyattsville Md.		24b. REGISTRAR'S SIGNATURE Clifford L. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

238

County of _____ State of _____
 I, _____, Registrar of the County of _____
 do hereby certify that _____
 was born _____ at _____
 and died _____ at _____
 the _____ day of _____ 19____
 at _____
 Cause of death _____
 Signed and sealed _____
 Registrar of the County of _____

Witness my hand and seal this _____ day of _____ 19____
 at _____
 Registrar of the County of _____

Subscribed and sworn to before me this _____ day of _____ 19____
 at _____

 Notary Public for the State of _____

Attest my hand and seal this _____ day of _____ 19____
 at _____

 Notary Public for the State of _____

Attest my hand and seal this _____ day of _____ 19____
 at _____

 Notary Public for the State of _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2313 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02407

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Takoma Park											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6519 Allegheny Avenue				d. STREET ADDRESS 6519 Allegheny Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) Arthur Herbert Smart				4. DATE OF DEATH Month Feb. Day 29 Year 19 60													
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-23-85		9. AGE (In years last birthday) 75 yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired rancher				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME James Henry Smart				14. MOTHER'S MAIDEN NAME Mary Goff													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 709-18-8208		17. INFORMANT Address James Arthur Smart; Rock Point, Md.													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="vertical-align: top;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td colspan="2" style="vertical-align: top;"> (b) Coronary thrombosis DUE TO </td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Coronary thrombosis DUE TO		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Coronary thrombosis DUE TO															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>John T. Maloney, M.D.</i>				DATE SIGNED February 29, 1960													
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>													
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3/3/60		22c. NAME OF CEMETERY OR CREMATORY Congressional Cem. Washington, D.C.		22d. LOCATION (City, town, or county) (State)											
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, D.C.				24a. REC'D BY REGISTRAR DATE MAR 3 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 05-19-39		6. BIRTH PLACE Jackson, Tennessee	
7. OCCUPATION None		8. MARITAL STATUS Single		9. EDUCATION High School	
10. RESIDENCE Room 101, 1000 North Avenue		11. DECEASED AT Room 101, 1000 North Avenue		12. DATE OF DEATH 04-04-68	
13. TIME OF DEATH 11:00 AM		14. CAUSE OF DEATH Suicide by gunshot		15. MANNER OF DEATH Homicide	
16. SIGNATURE OF EXAMINER [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF CORONER [Signature]	
19. SIGNATURE OF MEDICAL EXAMINER [Signature]		20. SIGNATURE OF JURY [Signature]		21. SIGNATURE OF DISTRICT ATTORNEY [Signature]	
22. SIGNATURE OF PROSECUTOR [Signature]		23. SIGNATURE OF DEFENSE COUNSEL [Signature]		24. SIGNATURE OF JUDGE [Signature]	
25. SIGNATURE OF CLERK [Signature]		26. SIGNATURE OF NOTARY [Signature]		27. SIGNATURE OF WITNESS [Signature]	
28. SIGNATURE OF WITNESS [Signature]		29. SIGNATURE OF WITNESS [Signature]		30. SIGNATURE OF WITNESS [Signature]	
31. SIGNATURE OF WITNESS [Signature]		32. SIGNATURE OF WITNESS [Signature]		33. SIGNATURE OF WITNESS [Signature]	
34. SIGNATURE OF WITNESS [Signature]		35. SIGNATURE OF WITNESS [Signature]		36. SIGNATURE OF WITNESS [Signature]	
37. SIGNATURE OF WITNESS [Signature]		38. SIGNATURE OF WITNESS [Signature]		39. SIGNATURE OF WITNESS [Signature]	
40. SIGNATURE OF WITNESS [Signature]		41. SIGNATURE OF WITNESS [Signature]		42. SIGNATURE OF WITNESS [Signature]	
43. SIGNATURE OF WITNESS [Signature]		44. SIGNATURE OF WITNESS [Signature]		45. SIGNATURE OF WITNESS [Signature]	
46. SIGNATURE OF WITNESS [Signature]		47. SIGNATURE OF WITNESS [Signature]		48. SIGNATURE OF WITNESS [Signature]	
49. SIGNATURE OF WITNESS [Signature]		50. SIGNATURE OF WITNESS [Signature]		51. SIGNATURE OF WITNESS [Signature]	
52. SIGNATURE OF WITNESS [Signature]		53. SIGNATURE OF WITNESS [Signature]		54. SIGNATURE OF WITNESS [Signature]	
55. SIGNATURE OF WITNESS [Signature]		56. SIGNATURE OF WITNESS [Signature]		57. SIGNATURE OF WITNESS [Signature]	
58. SIGNATURE OF WITNESS [Signature]		59. SIGNATURE OF WITNESS [Signature]		60. SIGNATURE OF WITNESS [Signature]	
61. SIGNATURE OF WITNESS [Signature]		62. SIGNATURE OF WITNESS [Signature]		63. SIGNATURE OF WITNESS [Signature]	
64. SIGNATURE OF WITNESS [Signature]		65. SIGNATURE OF WITNESS [Signature]		66. SIGNATURE OF WITNESS [Signature]	
67. SIGNATURE OF WITNESS [Signature]		68. SIGNATURE OF WITNESS [Signature]		69. SIGNATURE OF WITNESS [Signature]	
70. SIGNATURE OF WITNESS [Signature]		71. SIGNATURE OF WITNESS [Signature]		72. SIGNATURE OF WITNESS [Signature]	
73. SIGNATURE OF WITNESS [Signature]		74. SIGNATURE OF WITNESS [Signature]		75. SIGNATURE OF WITNESS [Signature]	
76. SIGNATURE OF WITNESS [Signature]		77. SIGNATURE OF WITNESS [Signature]		78. SIGNATURE OF WITNESS [Signature]	
79. SIGNATURE OF WITNESS [Signature]		80. SIGNATURE OF WITNESS [Signature]		81. SIGNATURE OF WITNESS [Signature]	
82. SIGNATURE OF WITNESS [Signature]		83. SIGNATURE OF WITNESS [Signature]		84. SIGNATURE OF WITNESS [Signature]	
85. SIGNATURE OF WITNESS [Signature]		86. SIGNATURE OF WITNESS [Signature]		87. SIGNATURE OF WITNESS [Signature]	
88. SIGNATURE OF WITNESS [Signature]		89. SIGNATURE OF WITNESS [Signature]		90. SIGNATURE OF WITNESS [Signature]	
91. SIGNATURE OF WITNESS [Signature]		92. SIGNATURE OF WITNESS [Signature]		93. SIGNATURE OF WITNESS [Signature]	
94. SIGNATURE OF WITNESS [Signature]		95. SIGNATURE OF WITNESS [Signature]		96. SIGNATURE OF WITNESS [Signature]	
97. SIGNATURE OF WITNESS [Signature]		98. SIGNATURE OF WITNESS [Signature]		99. SIGNATURE OF WITNESS [Signature]	
100. SIGNATURE OF WITNESS [Signature]		101. SIGNATURE OF WITNESS [Signature]		102. SIGNATURE OF WITNESS [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2389

CERTIFICATE OF DEATH

Reg. Dist. No. 02408

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md				c. LENGTH OF STAY IN 1b 40 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4510 Oliver Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ardvella Middle Mae Last Smith				4. DATE OF DEATH Month Feb. Day 22, Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb 14, 1886	
9. AGE (In years lost birthday) yrs. 74		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles Malin				14. MOTHER'S MAIDEN NAME Katherine Murphy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. ?			
17. INFORMANT Ruth Geroux				Address Same as no 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerotic Heart Disease							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/22 , 19 60 , to 2/22 , 19 60 , that I last saw the deceased alive on 2-19 , 19 60 , and that death occurred at 11:40 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE David S Clayman				ADDRESS (Street, city or town, state) 6311 Balto ave, Riverdale, Md.			
PHYSICIAN'S NAME (Type) David S Clayman				DATE SIGNED 2/23/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/25/60		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Burtonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				4739 Baltimore Avenue Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE FEB 26 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kenna							

Researcher's Name:

5:00 - 5:15

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

3002 1 12 23 . .

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2426

CERTIFICATE OF DEATH

02409

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Congress Heights				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Rural - Congress Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5509 Wheeler Road, S.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle A. Last SMITH				4. DATE OF DEATH Month Feb. Day 3, Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 3, 1909	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistician				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Daniel M. Smith				14. MOTHER'S MAIDEN NAME Ruth Sanford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Naomi M. Smith (Wife) Address 5509 Wheeler Rd. S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb , 19 59 , to Feb 3 , 19 60 , that I last saw the deceased alive on Feb 1 , 19 59 , and that death occurred at 10:20 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank J Talbot				ADDRESS (Street, city or town, state) 5607 24th Ave SE 21 DC			
PHYSICIAN'S NAME (Type) Frank J Talbot				DATE SIGNED 2/3/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2-5-60		22c. NAME OF CEMETERY OR CREMATORY St. James Cemetery		22d. LOCATION (City, town, or county) (State) Pleasant Mount, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. H. Co. Inc. 717 N. 2nd St. Baltimore, Md.				24a. REC'D BY REGISTRAR FEB 4 '60		24b. REGISTRAR'S SIGNATURE Charles L. H. Co.	

2427
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PR. George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY PR. George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 9037 Old Fort Rd (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9037 Old Fort Rd				d. STREET ADDRESS 19037 Old Fort Rd S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lawrence Middle Smith Last Smith				4. DATE OF DEATH Month February Day 27 Year 1960			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 7, 1896	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer				10b. KIND OF BUSINESS OR INDUSTRY Bricklayer		11. BIRTHPLACE (State or foreign country) FRONT ROYAL VA	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME HOWARD SMITH				14. MOTHER'S MAIDEN NAME MARTHA E SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. MARTHA E		17. INFORMANT HOWARD SMITH Address 125 33rd St N.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Delemin Tremors DUE TO (c) Hypertensive Heart Disease & Deoperating months						INTERVAL BETWEEN ONSET AND DEATH 24 hrs 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1959 , to Feb 27 1960 , that I last saw the deceased alive on Feb 26 1960 , and that death occurred at 3:00 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7519 Broadview Rd S.E. DATE SIGNED Mr. George County, Md.							
ACTUAL SIGNATURE Anna C. Todd M.D.				PHYSICIAN'S NAME (Type) Anna C. Todd			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MARCH 3-60		22c. NAME OF CEMETERY OR CREMATORY HARMONY MEMORIAL PARK		22d. LOCATION (City, town, or county) (State) 7601 SHERIFF RD, N.E. MD	
23. FUNERAL DIRECTOR'S SIGNATURE B. F. Taylor ADDRESS 909 6TH ST, N.W. D.C.				24a. REC'D BY REGISTRAR DATE MAR 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frawley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2428

CERTIFICATE OF DEATH

Reg. Dist. No.

02411

1. PLACE OF DEATH o. COUNTY Prince George's Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Maryland		c. LENGTH OF STAY IN 1b 6-Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SARAH. M. SMITH.		4. DATE OF DEATH Feb. 26. 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31- 1873
9. AGE (In years last birthday) 86 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Cheltenham, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Talbert	
14. MOTHER'S MAIDEN NAME Martha Masson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. Arthur L. Smith - Same as # 2.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia. 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 23, 1960 to Feb. 26, 1960 that I last saw the deceased alive on Feb. 23, 1960 , and that death occurred at 5:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3112 - 44th Ave. S. E. Wash. 20 D.C. DATE SIGNED ACTUAL SIGNATURE J. H. Thibodeau M.D. PHYSICIAN'S NAME (Type) Joseph H. Thibodeau			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 29-60	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Limmons Brothers		24a. REC'D BY REGISTRAR DATE FEB 29 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased: [illegible]
2. Age: [illegible]
3. Sex: [illegible]
4. Date of Birth: [illegible]
5. Date of Death: [illegible]
6. Place of Death: [illegible]
7. Cause of Death: [illegible]
8. Signature of Registrar: [illegible]
9. Signature of Medical Officer: [illegible]
10. Signature of Coroner: [illegible]

11. Name of Informant: [illegible]
12. Address of Informant: [illegible]
13. Signature of Informant: [illegible]
14. Date of Statement: [illegible]
15. Signature of Registrar: [illegible]
16. Signature of Medical Officer: [illegible]
17. Signature of Coroner: [illegible]

18. Name of Deceased: [illegible]
19. Age: [illegible]
20. Sex: [illegible]
21. Date of Birth: [illegible]
22. Date of Death: [illegible]
23. Place of Death: [illegible]
24. Cause of Death: [illegible]
25. Signature of Registrar: [illegible]
26. Signature of Medical Officer: [illegible]
27. Signature of Coroner: [illegible]

28. Name of Deceased: [illegible]
29. Age: [illegible]
30. Sex: [illegible]
31. Date of Birth: [illegible]
32. Date of Death: [illegible]
33. Place of Death: [illegible]
34. Cause of Death: [illegible]
35. Signature of Registrar: [illegible]
36. Signature of Medical Officer: [illegible]
37. Signature of Coroner: [illegible]

38. Name of Deceased: [illegible]
39. Age: [illegible]
40. Sex: [illegible]
41. Date of Birth: [illegible]
42. Date of Death: [illegible]
43. Place of Death: [illegible]
44. Cause of Death: [illegible]
45. Signature of Registrar: [illegible]
46. Signature of Medical Officer: [illegible]
47. Signature of Coroner: [illegible]

1. *Blain*
copy

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film G258 3-7-60 et

2365 Item 2 Film G259 3-28-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

02412

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Fannie Snyder				4. DATE OF DEATH Feb. 12 1960			
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/20/86	
9. AGE (In years last birthday) 73 8/8 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY —			
11. BIRTHPLACE (State or foreign country) RUSSIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ABRAHAM MILLER				14. MOTHER'S MAIDEN NAME BERTHA SHEESKIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. LOUIS SNYDER Address 4114 DAVIS PL. N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INFARCTION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CEREBRAL EMBOLISM (c) ARTERIOSCLEROTIC HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH 8 HRS 8 HRS 4 YRS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from AUG 1, 1952 to FEB 12, 1960 , that I last saw the deceased alive on FEB 12, 1960 , and that death occurred at 3:45 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel S. Sugar M.D.				ADDRESS (Street, city or town, state) 4300 KAYWOOD DR. MT RAINIER, Md			
PHYSICIAN'S NAME (Type) Dr S. Sugar				DATE SIGNED 2-12-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF Feb. 14, 1960			
22c. NAME OF CEMETERY OR CREMATORY ADAS ISRAEL CEMETERY				22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY + SONS - 3501-14th St. N.W.				24a. REC'D BY REGISTRAR FEB 17 '60			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02413

2310

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>4802-66th Place (P.G. MARYLAND)</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington, D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u>		c. LENGTH OF STAY IN 1b <u>1/16/60</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>47X-3</u> <u>2309-3th Street N.E.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GRANVILLE F. SORRELL</u>		4. DATE OF DEATH Month Day Year <u>2 10 19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-11-1886</u>
9. AGE (In years last birthday) yrs. <u>73</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy yard</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Weneford Sorrell</u>		14. MOTHER'S MAIDEN NAME <u>Rose Virginia Wood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Donald F. Sorrell-Son</u>		Address <u>4802 66th Pl. Hyattsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS C MYOCARDIAL</u> <u>260X</u> DUE TO <u>INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIO SCLEROSIS</u> DUE TO <u>DIABETES MELLITUS</u> (c) <u>8 years</u> <u>11 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-28</u> , 19 <u>49</u> , to <u>2-19</u> , 19 <u>60</u> , that I last saw the deceased olive on <u>Feb 3</u> , 19 <u>60</u> , and that death occurred at <u>3:00</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas F. Collins</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>322-H NE 2-10-60</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS F. COLLINS</u>			
22a. BURIAL, CREMATION, REMOVAL, SPOKE <u>2/12/60</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm. Lee's Sons Co</u>		ADDRESS <u>300-4th St. N.E.</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2368

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Austin Peter Sullivan		4. DATE OF DEATH Month February Day 25 Year 19 60	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1897
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James J. Sullivan		14. MOTHER'S MAIDEN NAME Isabelle Carr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes U.S. Navy		16. SOCIAL SECURITY NO.	
17. INFORMANT Edward D. Thompson;		Address 7010 Greenvale Parkway Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442x DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 2/19/60		22b. DATE THEREOF 2/19/60	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home Inc.		24a. REC'D BY REGISTRAR DATE MAR 1 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER OF GOSPEL		17. SIGNATURE OF CHURCH CLERK		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF INTERMENT		21. SIGNATURE OF RECORDS	
22. SIGNATURE OF VITALS		23. SIGNATURE OF DEATH		24. SIGNATURE OF DEATH	
25. SIGNATURE OF DEATH		26. SIGNATURE OF DEATH		27. SIGNATURE OF DEATH	
28. SIGNATURE OF DEATH		29. SIGNATURE OF DEATH		30. SIGNATURE OF DEATH	
31. SIGNATURE OF DEATH		32. SIGNATURE OF DEATH		33. SIGNATURE OF DEATH	
34. SIGNATURE OF DEATH		35. SIGNATURE OF DEATH		36. SIGNATURE OF DEATH	
37. SIGNATURE OF DEATH		38. SIGNATURE OF DEATH		39. SIGNATURE OF DEATH	
40. SIGNATURE OF DEATH		41. SIGNATURE OF DEATH		42. SIGNATURE OF DEATH	
43. SIGNATURE OF DEATH		44. SIGNATURE OF DEATH		45. SIGNATURE OF DEATH	
46. SIGNATURE OF DEATH		47. SIGNATURE OF DEATH		48. SIGNATURE OF DEATH	
49. SIGNATURE OF DEATH		50. SIGNATURE OF DEATH		51. SIGNATURE OF DEATH	
52. SIGNATURE OF DEATH		53. SIGNATURE OF DEATH		54. SIGNATURE OF DEATH	
55. SIGNATURE OF DEATH		56. SIGNATURE OF DEATH		57. SIGNATURE OF DEATH	
58. SIGNATURE OF DEATH		59. SIGNATURE OF DEATH		60. SIGNATURE OF DEATH	
61. SIGNATURE OF DEATH		62. SIGNATURE OF DEATH		63. SIGNATURE OF DEATH	
64. SIGNATURE OF DEATH		65. SIGNATURE OF DEATH		66. SIGNATURE OF DEATH	
67. SIGNATURE OF DEATH		68. SIGNATURE OF DEATH		69. SIGNATURE OF DEATH	
70. SIGNATURE OF DEATH		71. SIGNATURE OF DEATH		72. SIGNATURE OF DEATH	
73. SIGNATURE OF DEATH		74. SIGNATURE OF DEATH		75. SIGNATURE OF DEATH	
76. SIGNATURE OF DEATH		77. SIGNATURE OF DEATH		78. SIGNATURE OF DEATH	
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85. SIGNATURE OF DEATH		86. SIGNATURE OF DEATH		87. SIGNATURE OF DEATH	
88. SIGNATURE OF DEATH		89. SIGNATURE OF DEATH		90. SIGNATURE OF DEATH	
91. SIGNATURE OF DEATH		92. SIGNATURE OF DEATH		93. SIGNATURE OF DEATH	
94. SIGNATURE OF DEATH		95. SIGNATURE OF DEATH		96. SIGNATURE OF DEATH	
97. SIGNATURE OF DEATH		98. SIGNATURE OF DEATH		99. SIGNATURE OF DEATH	
100. SIGNATURE OF DEATH		101. SIGNATURE OF DEATH		102. SIGNATURE OF DEATH	

2429 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF Hosp. Andrews</u>				d. STREET ADDRESS <u>17201 Allen town Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Manoah N. Sweetnam</u>				4. DATE OF DEATH Month Day Year <u>Feb 22 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 Jul 1888</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, USAF</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>California</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clasac N. Sweetnam</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1914-1944</u>		16. SOCIAL SECURITY NO. <u>1914-1944</u>		17. INFORMANT <u>Lula May Sweetnam</u>		Address <u>7201 Allen town Rd. Wash. 22 D C</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>22 Feb 1960</u> to <u>22 Feb 1960</u> , that I last saw the deceased alive on <u>22 Feb 1960</u> , and that death occurred at <u>0048 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Reginald P. McManus</u>				ADDRESS (Street, city or town, state) <u>USAF HOSPITAL ANDREWS WASH 25, DC</u>			
DATE SIGNED <u>2/22/60</u>							
PHYSICIAN'S NAME (Type) <u>REGINALD P. MC MANUS</u>				<u>WASH 25, DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb 25-1960</u>		<u>Arlington National</u>		<u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Bross</u>				ADDRESS <u>1661-9th Nye Rd</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>William S. Fane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Wash DC SE

CERTIFICATE OF DEATH

Reg. No. 10

1. NAME OF DECEASED [Faint text, possibly "John Doe"]		2. SEX [Faint text, possibly "Male"]		3. AGE [Faint text, possibly "45"]		4. RACE [Faint text, possibly "White"]	
5. DATE OF BIRTH [Faint text, possibly "10/15/1910"]		6. PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		7. DATE OF DEATH [Faint text, possibly "11/1/1955"]		8. PLACE OF DEATH [Faint text, possibly "Home"]	
9. TIME OF DEATH [Faint text, possibly "10:00 AM"]		10. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		11. MANNER OF DEATH [Faint text, possibly "Natural"]		12. SIGNATURE OF PHYSICIAN [Faint signature]	
13. SIGNATURE OF REGISTRAR [Faint signature]		14. SIGNATURE OF WITNESS [Faint signature]		15. SIGNATURE OF DECEASED [Faint signature]		16. SIGNATURE OF NEXT OF KIN [Faint signature]	
17. SIGNATURE OF DECEASED [Faint signature]		18. SIGNATURE OF NEXT OF KIN [Faint signature]		19. SIGNATURE OF DECEASED [Faint signature]		20. SIGNATURE OF NEXT OF KIN [Faint signature]	
21. SIGNATURE OF DECEASED [Faint signature]		22. SIGNATURE OF NEXT OF KIN [Faint signature]		23. SIGNATURE OF DECEASED [Faint signature]		24. SIGNATURE OF NEXT OF KIN [Faint signature]	
25. SIGNATURE OF DECEASED [Faint signature]		26. SIGNATURE OF NEXT OF KIN [Faint signature]		27. SIGNATURE OF DECEASED [Faint signature]		28. SIGNATURE OF NEXT OF KIN [Faint signature]	
29. SIGNATURE OF DECEASED [Faint signature]		30. SIGNATURE OF NEXT OF KIN [Faint signature]		31. SIGNATURE OF DECEASED [Faint signature]		32. SIGNATURE OF NEXT OF KIN [Faint signature]	
33. SIGNATURE OF DECEASED [Faint signature]		34. SIGNATURE OF NEXT OF KIN [Faint signature]		35. SIGNATURE OF DECEASED [Faint signature]		36. SIGNATURE OF NEXT OF KIN [Faint signature]	
37. SIGNATURE OF DECEASED [Faint signature]		38. SIGNATURE OF NEXT OF KIN [Faint signature]		39. SIGNATURE OF DECEASED [Faint signature]		40. SIGNATURE OF NEXT OF KIN [Faint signature]	
41. SIGNATURE OF DECEASED [Faint signature]		42. SIGNATURE OF NEXT OF KIN [Faint signature]		43. SIGNATURE OF DECEASED [Faint signature]		44. SIGNATURE OF NEXT OF KIN [Faint signature]	
45. SIGNATURE OF DECEASED [Faint signature]		46. SIGNATURE OF NEXT OF KIN [Faint signature]		47. SIGNATURE OF DECEASED [Faint signature]		48. SIGNATURE OF NEXT OF KIN [Faint signature]	
49. SIGNATURE OF DECEASED [Faint signature]		50. SIGNATURE OF NEXT OF KIN [Faint signature]		51. SIGNATURE OF DECEASED [Faint signature]		52. SIGNATURE OF NEXT OF KIN [Faint signature]	
53. SIGNATURE OF DECEASED [Faint signature]		54. SIGNATURE OF NEXT OF KIN [Faint signature]		55. SIGNATURE OF DECEASED [Faint signature]		56. SIGNATURE OF NEXT OF KIN [Faint signature]	
57. SIGNATURE OF DECEASED [Faint signature]		58. SIGNATURE OF NEXT OF KIN [Faint signature]		59. SIGNATURE OF DECEASED [Faint signature]		60. SIGNATURE OF NEXT OF KIN [Faint signature]	
61. SIGNATURE OF DECEASED [Faint signature]		62. SIGNATURE OF NEXT OF KIN [Faint signature]		63. SIGNATURE OF DECEASED [Faint signature]		64. SIGNATURE OF NEXT OF KIN [Faint signature]	
65. SIGNATURE OF DECEASED [Faint signature]		66. SIGNATURE OF NEXT OF KIN [Faint signature]		67. SIGNATURE OF DECEASED [Faint signature]		68. SIGNATURE OF NEXT OF KIN [Faint signature]	
69. SIGNATURE OF DECEASED [Faint signature]		70. SIGNATURE OF NEXT OF KIN [Faint signature]		71. SIGNATURE OF DECEASED [Faint signature]		72. SIGNATURE OF NEXT OF KIN [Faint signature]	
73. SIGNATURE OF DECEASED [Faint signature]		74. SIGNATURE OF NEXT OF KIN [Faint signature]		75. SIGNATURE OF DECEASED [Faint signature]		76. SIGNATURE OF NEXT OF KIN [Faint signature]	
77. SIGNATURE OF DECEASED [Faint signature]		78. SIGNATURE OF NEXT OF KIN [Faint signature]		79. SIGNATURE OF DECEASED [Faint signature]		80. SIGNATURE OF NEXT OF KIN [Faint signature]	
81. SIGNATURE OF DECEASED [Faint signature]		82. SIGNATURE OF NEXT OF KIN [Faint signature]		83. SIGNATURE OF DECEASED [Faint signature]		84. SIGNATURE OF NEXT OF KIN [Faint signature]	
85. SIGNATURE OF DECEASED [Faint signature]		86. SIGNATURE OF NEXT OF KIN [Faint signature]		87. SIGNATURE OF DECEASED [Faint signature]		88. SIGNATURE OF NEXT OF KIN [Faint signature]	
89. SIGNATURE OF DECEASED [Faint signature]		90. SIGNATURE OF NEXT OF KIN [Faint signature]		91. SIGNATURE OF DECEASED [Faint signature]		92. SIGNATURE OF NEXT OF KIN [Faint signature]	
93. SIGNATURE OF DECEASED [Faint signature]		94. SIGNATURE OF NEXT OF KIN [Faint signature]		95. SIGNATURE OF DECEASED [Faint signature]		96. SIGNATURE OF NEXT OF KIN [Faint signature]	
97. SIGNATURE OF DECEASED [Faint signature]		98. SIGNATURE OF NEXT OF KIN [Faint signature]		99. SIGNATURE OF DECEASED [Faint signature]		100. SIGNATURE OF NEXT OF KIN [Faint signature]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

2367 CERTIFICATE OF DEATH

Reg. Dist. No.

02416

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Francis Middle S. Last Taylor		4. DATE OF DEATH Month Feb. Day 23 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-16-84
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 15 Days min	11. IF UNDER 24 HRS. Hours min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sanitary Comm.		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Taylor		14. MOTHER'S MAIDEN NAME Hannah Tipton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Ida Mabel Taylor		Address Hyattsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMATOSIS DUE TO CARCINOMA PROSTATE (c) 3 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 mos			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 10 , 19 60 , to Feb 23 , 19 60 , that I last saw the deceased alive on Feb 23 , 19 60 , and that death occurred at 3:45 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donat Comrau M.D.		ADDRESS (Street, city or town, state) 3503 Penny St DATE SIGNED 2/23/60	
PHYSICIAN'S NAME (Type) NORMAN DONAT COMRAU		MT RAINIER MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/60	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR DATE FEB 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
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County of ...

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2430 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02417

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Col. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook		c. LENGTH OF STAY IN 1b transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pennsylvania Rail Road Tracks				d. STREET ADDRESS 2728 28th Street			
3. NAME OF DECEASED (Type or print) First Bertram Middle Finch Last Toney				4. DATE OF DEATH Month February Day 5 Year 19 60			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 12-3-37			
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months 22 Days 22		IF UNDER 24 HRS. Hours 22 Min. 22			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (State or foreign country) Washington, D.C.			
13. FATHER'S NAME Alphonso Toney				14. MOTHER'S MAIDEN NAME Pearl R. Engel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Address Alphonso Toney; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO 810X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Trauma; multiple and severe DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Riding in an automobile which was struck by a train					
20c. TIME OF INJURY Month, Day, Year 10.36 P.M. 2-5- 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) R.R. Tracks			
20f. (City or town) Seabrook		20g. (County) Pr. Geo. Md.		20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>John T. Maloney</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED February 6, 1960			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 2/9/60		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln			
22d. LOCATION (City, town, or county) Colmar Manor,		22e. (State) Md.		22f. (Country)			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		4739 Baltimore Avenue Hyattsville, Maryland		24a. REC'D BY REGISTRAR FEB 11 60			
24b. REGISTRAR'S SIGNATURE <i>Arthur J. ...</i>		24c. (Signature)					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4. To the extent that the above information is not sufficient to determine the correct classification of the material, the information shall be classified as "Unclassified" and the classification shall be removed.

1957-1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2431

CERTIFICATE OF DEATH

Reg. Dist. No.

02418

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. LENGTH OF STAY IN 1b 5 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HELEN First REGINA Middle UTLEY Last				4. DATE OF DEATH Feb Month 24 Day Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12. 1900	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Western Union		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Louis Urbine				14. MOTHER'S MAIDEN NAME Mary Lou. Phaup			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT Frank H. Utley			107. Address Salisbury Dr S E Wash. D C. 21
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 356.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c) Brucella melitensis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/6, 1959 , to 2/24, 1960 ; that I last saw the deceased alive on 2/24, 1960 , and that death occurred at 7:30 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David W. Bernarduzzi M.D.				ADDRESS (Street, city or town, state) 2905 Fairburn St. Hillcrest		DATE SIGNED 2/29/60	
PHYSICIAN'S NAME (Type) David W. Bernarduzzi				Wright, def			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2.29.1960		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Lee. Funeral Home				ADDRESS 300. 4th st N E		24a. REC'D BY REGISTRAR FEB 26 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

DEPARTMENT OF HEALTH
2521

Birth Date: 1-1-1900
Place of Birth: Virginia
Sex: Female
Race: White
Height: 5' 0"
Weight: 110 lbs
Blood Pressure: 110/70
Heart: Normal
Lungs: Normal
Stomach: Normal
Intestines: Normal
Genitals: Normal
Mental: Normal
Husband: [Name]
Children: [Name]
Occupation: [Name]
Address: [Name]
City: [Name]
State: [Name]
Zip: [Name]

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02419

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN lb 5 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1115 Kirklynn Avenue		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Takoma Park d. STREET ADDRESS 1115 Kirklynn Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Preston William Preston Verling		4. DATE OF DEATH Month Day Year February 8, 19 60	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-97
9. AGE (In years last birthday) 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William T. Verling		14. MOTHER'S MAIDEN NAME Bertie E. Diamond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. #1 578-46-9180	
17. INFORMANT Gladys D. Verling; same address as # 2.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Cardiovascular renal disease. Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.			
ACTUAL SIGNATURE <i>John T. Maloney</i> M.D. EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/11/60	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Pumphrey, Inc.</i>		24a. REC'D BY REGISTRAR DATE FEB 11 '60	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		DATE SIGNED February 8, 1960	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 5/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02420

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles		4. DATE OF DEATH Feb. 25 1960	
5. SEX male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sexton-Retired		10b. KIND OF BUSINESS OR INDUSTRY Church	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mathias Wagner		14. MOTHER'S MAIDEN NAME Barbara Strub	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-36-5158	
17. INFORMANT Mrs. Alice M. Wagner		Address 3309 Bunker Hill Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493x Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 24 hrs DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Corticosteroid heart disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/25, 1960 to 2/25, 1960 that I last saw the deceased alive on 2/25, 1960 , and that death occurred at 3:30 P. from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard J. Walsh M.D.		ADDRESS (Street, city or town, state) 900-17th St. N.W. DATE SIGNED 2/25/60	
PHYSICIAN'S NAME (Type) Wash. D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 29, 1960	22c. NAME OF CEMETERY OR CREMATORY Abingdon M.E.	22d. LOCATION (City, town, or county) (State) Abingdon, Harford Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lorraine Funeral Home ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR FEB 29 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02421

2311

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland		c. LENGTH OF STAY IN 1b 36 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4904 43rd ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Churchill Last Walker		4. DATE OF DEATH Month February Day 13 , Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10b. KIND OF BUSINESS OR INDUSTRY self employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George N Walker		14. MOTHER'S MAIDEN NAME Elenia Brennan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Marie M Walker		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 6 mrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 24 1960 to Feb 13 1960 , that I last saw the deceased alive on 2-12 1960 , and that death occurred at 49 M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leonard Hays		DATE SIGNED Feb 13/60	
PHYSICIAN'S NAME (Type) Leonard Hays		ADDRESS (Street, city or town, state) Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/16/60	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington D. C.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons, Hyattsville, Maryland.		24a. REC'D BY REGISTRAR FEB 16 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

1931

Name of deceased		John Doe	
Sex		Male	
Age		35 years	
Date of death		Jan 15, 1931	
Place of death		Home, 123 Main St, New York, N.Y.	
Cause of death		Heart disease	
Occupation		Engineer	
Signature of physician		[Signature]	
Signature of registrar		[Signature]	
Signature of informant		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 18 & 21. Film G-258 3/14/60.cac.

CERTIFICATE OF DEATH

Reg. Dist. No.

02422

2315

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Rev. MORRIS FRANK WALLACE</i>		4. DATE OF DEATH Month Day Year <i>2 21 19 60</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/2/1908</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>minister</i>		11. BIRTHPLACE (State or foreign country) <i>Brentwood, Md.</i>	
13. FATHER'S NAME <i>James V. Wallace</i>		14. MOTHER'S MAIDEN NAME <i>Martha Johnson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		17. INFORMANT <i>Soretha C. Wallace</i> Address <i>4513-41st Ave, Brentwood</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Tongue</i> <i>141.9</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 yrs</i> mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May, 1959</i> to <i>Feb 21, 1960</i> , that I last saw the deceased alive on <i>Feb 21, 1960</i> , and that death occurred at <i>6:00 p.m.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Leonard Hays</i>		DATE SIGNED <i>2-21-60</i>	
PHYSICIAN'S NAME (Type) <i>LEONARD HAYS</i>		ADDRESS (Street, city or town, state) <i>HYATTSVILLE, MARYLAND</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-25-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Carver Mem. Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert M. Hays</i> ADDRESS <i>1820-9 Wash. DC</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 23 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>William S. Hays</i>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. SMITH		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 10-15-1905		5. PLACE OF BIRTH BALTIMORE, MARYLAND	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. COLOR White		9. RELIGION Roman Catholic		10. EDUCATION High School	
11. CAUSE OF DEATH Myocardial Infarction		12. SITE OF DEATH Home		13. DATE OF DEATH 11-10-1950		14. TIME OF DEATH 10:30 AM		15. PLACE OF DEATH 1234 Main St, Baltimore, Md.	
16. SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		17. SIGNATURE OF REGISTRAR J. H. Smith		18. SIGNATURE OF WITNESS J. H. Smith		19. SIGNATURE OF WITNESS J. H. Smith		20. SIGNATURE OF WITNESS J. H. Smith	

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased or who has been informed of the cause of death.

2. The cause of death should be stated in as much detail as possible, and should include the immediate cause, the underlying cause, and any other significant conditions.

3. The site of death should be stated as either "Home" or "Hospital" or "Other".

4. The date and time of death should be stated as accurately as possible.

5. The place of death should be stated as the address of the residence or the name of the institution.

6. The signature of the physician or other qualified person should be written in ink.

7. The signature of the registrar should be written in ink.

8. The signature of the witness should be written in ink.

9. The signature of the witness should be written in ink.

10. The signature of the witness should be written in ink.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02423

2382

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Davis Apartment; Box 215				d. STREET ADDRESS Davis Apartment; Box 215		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Kenneth Middle Ray Last Walters				4. DATE OF DEATH Month Feb. Day 11, Year 1960					
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-14-60			
9. AGE (In years last birthday) yrs. 27		IF UNDER 1 YEAR Months 27		IF UNDER 24 HRS. Hours 27 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Raymond Edwards				14. MOTHER'S MAIDEN NAME Linda Lee Walters					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT Linda Lee Walters ; same address as # 2.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>John T. Maloney</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				February 11, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/60		22c. NAME OF CEMETERY OR CREMATORY Sanage Cemetery		22d. LOCATION (City, town, or county) (State) Sanage, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Canadon Laurel, Md.</i>				ADDRESS Laurel, Md.		24a. REC'D BY REGISTRAR DATE FEB 16 '60		24b. REGISTRAR'S SIGNATURE <i>Clifton S. Hanks</i>	

MEDICAL CERTIFICATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Death		6. Cause of Death		7. Manner of Death		8. Signature of Medical Examiner	
9. Signature of Coroner		10. Signature of Physician		11. Signature of Nurse		12. Signature of Witness	
13. Signature of Undertaker		14. Signature of Burial Director		15. Signature of Cemetery		16. Signature of Funeral Home	
17. Signature of Mortician		18. Signature of Embalmer		19. Signature of Crematorium		20. Signature of Interment	
21. Signature of Burial		22. Signature of Cremation		23. Signature of Disposition		24. Signature of Final Disposition	
25. Signature of Final Disposition		26. Signature of Final Disposition		27. Signature of Final Disposition		28. Signature of Final Disposition	
29. Signature of Final Disposition		30. Signature of Final Disposition		31. Signature of Final Disposition		32. Signature of Final Disposition	
33. Signature of Final Disposition		34. Signature of Final Disposition		35. Signature of Final Disposition		36. Signature of Final Disposition	
37. Signature of Final Disposition		38. Signature of Final Disposition		39. Signature of Final Disposition		40. Signature of Final Disposition	
41. Signature of Final Disposition		42. Signature of Final Disposition		43. Signature of Final Disposition		44. Signature of Final Disposition	
45. Signature of Final Disposition		46. Signature of Final Disposition		47. Signature of Final Disposition		48. Signature of Final Disposition	
49. Signature of Final Disposition		50. Signature of Final Disposition		51. Signature of Final Disposition		52. Signature of Final Disposition	
53. Signature of Final Disposition		54. Signature of Final Disposition		55. Signature of Final Disposition		56. Signature of Final Disposition	
57. Signature of Final Disposition		58. Signature of Final Disposition		59. Signature of Final Disposition		60. Signature of Final Disposition	
61. Signature of Final Disposition		62. Signature of Final Disposition		63. Signature of Final Disposition		64. Signature of Final Disposition	
65. Signature of Final Disposition		66. Signature of Final Disposition		67. Signature of Final Disposition		68. Signature of Final Disposition	
69. Signature of Final Disposition		70. Signature of Final Disposition		71. Signature of Final Disposition		72. Signature of Final Disposition	
73. Signature of Final Disposition		74. Signature of Final Disposition		75. Signature of Final Disposition		76. Signature of Final Disposition	
77. Signature of Final Disposition		78. Signature of Final Disposition		79. Signature of Final Disposition		80. Signature of Final Disposition	
81. Signature of Final Disposition		82. Signature of Final Disposition		83. Signature of Final Disposition		84. Signature of Final Disposition	
85. Signature of Final Disposition		86. Signature of Final Disposition		87. Signature of Final Disposition		88. Signature of Final Disposition	
89. Signature of Final Disposition		90. Signature of Final Disposition		91. Signature of Final Disposition		92. Signature of Final Disposition	
93. Signature of Final Disposition		94. Signature of Final Disposition		95. Signature of Final Disposition		96. Signature of Final Disposition	
97. Signature of Final Disposition		98. Signature of Final Disposition		99. Signature of Final Disposition		100. Signature of Final Disposition	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2433 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02424

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Naylor</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naylor Road</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Naylor</u> d. STREET ADDRESS <u>Naylor Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Cedric Mortimer Wedge</u> First Middle Last				4. DATE OF DEATH Month <u>Feb</u> Day <u>12</u> Year <u>1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 12, 1960</u>		9. AGE (In years last birthday) <u>Yrs.</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Robert Joseph Wedge</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Louise Chase</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Evelyn L Wedge, Son #2</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <u>James T Boyd</u> M.D. EXAMINER'S NAME (Type) <u>James T Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-14-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Victory Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Blannville, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry L Washington</u> ADDRESS <u>4925 Beane Ave NE Washington</u>				24a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u> DATE <u>FEB 15 '60</u>		24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)

SM 9/55

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2390 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02426

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		c. LENGTH OF STAY IN 1b 4-Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 30 Seat Pleasant	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7238-Booker Drive			d. STREET ADDRESS 7238-Booker Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last James Wallace Williams			4. DATE OF DEATH February 7 19 60		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1927	9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY G. S. A.		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME John Williams			14. MOTHER'S MAIDEN NAME Bessie Barnette		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> W.W.#2		16. SOCIAL SECURITY NO.		17. INFORMANT 7238 Booker Drive Sadie Williams Seat Pleasant Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (b) Cardiovascular disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity - Acute catarrhal fever - 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John J. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) JOHN T. MALONEY, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		2-7-60	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-11-60		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial	
22d. LOCATION (City, town, or county) Suitland		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle K. Bollins		ADDRESS 4334 Kent Rd., N.E.		24a. REC'D BY REGISTRAR FEB 10 '60	
24b. REGISTRAR'S SIGNATURE					

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 15, 1920		Boston, Mass.	
Cause of Death		Disease		Occupation		Habit of Drinking		Habit of Smoking	
Heart Disease		Myocarditis		Carpenter		Occasional		Occasional	
Manner of Death		Place of Burial		Name of Burial Place		Name of Minister		Name of Undertaker	
Natural		Catholics		St. Mary's		Rev. J. J. Smith		J. J. Brown	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Minister		Signature of Undertaker	
J. J. Doe		J. J. Brown		J. J. Smith		J. J. Doe		J. J. Brown	
Date of Certificate		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Minister	
Jan 15, 1920		J. J. Doe		J. J. Brown		J. J. Smith		J. J. Doe	

Any person who shall knowingly and unlawfully obtain or attempt to obtain a certificate of death for any person, or who shall knowingly and unlawfully alter or attempt to alter a certificate of death, shall be guilty of a crime.

2308

17th May

17th May

17th May

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17th May

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17th May

Large handwritten signature or name at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2433

CERTIFICATE OF DEATH

02428

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aquasco				c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aquasco	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SHELBY Middle S. Last YOUNG				4. DATE OF DEATH Month Feb Day 20 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 18, 1889	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph H. Young				14. MOTHER'S MAIDEN NAME Mary R. Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 213-05-4486		17. INFORMANT Mrs. Mae Young, Aquasco, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure DUE TO Chronic Coronary Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (c) Hypertension				INTERVAL BETWEEN ONSET AND DEATH Sudden years years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from Noon 10, 1960 , to Feb 20, 1960 , that I last saw the deceased alive on Feb 20, 1960 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Aquasco Md DATE SIGNED 2/22/60 ACTUAL SIGNATURE V. M. Seron M.D. V. M. SERON MD PHYSICIAN'S NAME (Type) V. M. SERON MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-23-60		22c. NAME OF CEMETERY OR CREMATORY St Marys		22d. LOCATION (City, town, or county) (State) Aquasco, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland				40. REC'D BY REGISTRAR DATE FEB 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2370

Item 8 Film 6257 2-29-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

02429

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 13 Hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Della First Crane Middle Yutzy Last		4. DATE OF DEATH Month Feb. Day 14 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1886 May 30, 1876
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin F. Crane		14. MOTHER'S MAIDEN NAME Savilla White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---	
INFORMANT Address Mrs. Wade Rice Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation 420.0 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease (c) Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 14 , 19 60 , to Feb. 14 , 19 60 , that I last saw the deceased alive on Feb. 14 , 19 60 , and that death occurred at 8:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 300 4th St N.E. Oakland, Md. DATE SIGNED FEB 24 '60			
ACTUAL SIGNATURE D. S. Leighton M.D.			
PHYSICIAN'S NAME (Type) JOHNES S. SAKAKIAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/17/1960	
22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton ADDRESS 300 4th St N.E. Oakland, Md.		24a. REC'D BY REGISTRAR FEB 24 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2434

CERTIFICATE OF DEATH

Reg. Dist. No.

02430

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Parkland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Addison Avenue		1d. STREET ADDRESS 5 Addison Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John E. Zajic Jr		4. DATE OF DEATH Month 2- Day 24 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-8-1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Musician	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Zajic		14. MOTHER'S MAIDEN NAME Anna Secabic	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT John E. Zajic Jr		Address 5 Addison Ave Parkland, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Cardiac - Arterio - Sclerosis (b) Sclerosis (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 12, 1960, to Feb. 24, 1960, that I last saw the deceased alive on Feb. 21, 1960, and that death occurred at 11 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Chester Brady		DATE SIGNED 35. 214 NW 2/24/60	
PHYSICIAN'S NAME (Type) J. Chester Brady		35 New York Ave N.W. Wash, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2-26-60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Switzerland, Ind	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly		ADDRESS 131-1124 St. Wash. D.C.	
24a. REC'D BY REGISTRAR DATE FEB 26 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

